Name: ____________________ Date: ____________________

REVIEW OF SYSTEMS

Do you have any of the following? Please circle yes or no for each item.

General:

Recent weight loss of more than 10 pounds	Yes	No
Recent weight *gain of more* than 10 pounds	Yes	No
Seen primary care physician in last year	Yes	No
Fever	Yes	No
Chills	Yes	No
Night Sweats	Yes	No

Cardiac

Chest Pain	Yes	No
Shortness of Breath	Yes	No

Respiratory

Wheezing	Yes	No
Pneumonia	Yes	No
Chronic Cough	Yes	No

Gastrointestinal:

Abdominal pain	Yes	No
Nausea	Yes	No
Vomiting	Yes	No
Diarrhea	Yes	No
Liver problems	Yes	No

Skin:

Open sores	Yes	No
New moles	Yes	No
Poor healing	Yes	No
Skin infection	Yes	*No*

Hematologic/Oncologic:

Easy bruising	Yes	No
Blood thinning medications	Yes	No
Blood transfusion	Yes	No
Organ transplant	Yes	No

Bones/ Joints:

Shoulder pain	Yes	No
Wrist or hand pain	Yes	No
Hip pain	Yes	No
Knee pain	Yes	No
Lupus	Yes	No
Muscle weakness	Yes	No
Fibromyalgia	Yes	No

Genitourinary:

Abnormal kidney fimetion	Yes	No
Pain with urination	Yes	No
Frequent urinary infections	Yes	No

Mental Health:

Sleep disturbance	Yes	No
Feeling *of* hopelessness	Yes	No

Nervous System:

Headaches	Yes	No
Tremors	Yes	No
Poor speech	Yes	No
Changes in vision	Yes	No

Endocrine:

Thyroid problems	Yes	No

Patient's initials __________ Date ______________

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