Name:_______________________________________ Date of Birth:_____________ Date:____________

REVIEW OF SYSTEMS

Have you experienced any of the following symptoms in the past month?

CONSTITUTIONAL

Activity change	No	Yes
Appetite change	No	Yes
Chills	No	Yes
Excessive sweating	No	Yes
Fatigue	No	Yes
Fever	No	Yes
Unexpected weight change	No	Yes

HEENT

Facial swelling	No	Yes
Neck pain	No	Yes
Neck stiffness	No	Yes
Ear discharge	No	Yes
Hearing loss	No	Yes
Ear pain	No	Yes
Ringing in ears	No	Yes
Nosebleeds	No	Yes
Congestion	No	Yes
Runny nose	No	Yes
Postnasal drip	No	Yes
Sneezing	No	Yes
Sinus pressure	No	Yes
Dental problem	No	Yes
Drooling	No	Yes
Mouth sores	No	Yes
Sore throat	No	Yes
Trouble swallowing	No	Yes
Voice change	No	Yes

EYES

Eye discharge	No	Yes
Eye itching	No	Yes
Eye pain	No	Yes
Eye redness	No	Yes
Light sensitivity	No	Yes
Visual disturbance	No	Yes

RESPIRATORY

Apnea /not breathing	No	Yes
Chest tightness	No	Yes
Choking	No	Yes
Cough	No	Yes
Shortness of breath	No	Yes
Wheezing	No	Yes

CARDIOVASCULAR

Chest pain	No	Yes
Leg swelling	No	Yes
Palpitations	No	Yes

GASTROINTESTINAL

Abdominal distention (bloating)	No	Yes
Abdominal pain	No	Yes
Anal bleeding	No	Yes
Blood in stool	No	Yes
Constipation	No	Yes
Diarrhea	No	Yes
Nausea	No	Yes
Rectal pain	No	Yes
Vomiting	No	Yes

ENDOCRINE

Cold intolerance	No	Yes
Heat intolerance	No	Yes
Polydipsia / increased thirst	No	Yes
Polyphagia / increased appetite	No	Yes
Polyuria / frequent urination	No	Yes

Name:_______________________________________ Date of Birth:_____________ Date:____________

REVIEW OF SYSTEMS

Have you experienced any of the following symptoms in the past month?

GENITOURINARY

Difficulty urinating	No	Yes
Dysuria /painful urination	No	Yes
Enuresis / incontinence	No	Yes
Flank pain	No	Yes
Frequency	No	Yes
Genital sore	No	Yes
Hematuria / blood in urine	No	Yes
Penile discharge	No	Yes
Penile pain	No	Yes
Penile swelling	No	Yes
Scrotal swelling	No	Yes
Testicular pain	No	Yes
Urgency	No	Yes
Urine decreased	No	Yes

Muscular

Arthralgias /joint pain	No	Yes
Back pain	No	Yes
Gait problem	No	Yes
Joint swelling	No	Yes
Myalgias / pain in muscles	No	Yes

Skin

Color change	No	Yes
Pallor	No	Yes
Rash	No	Yes
Wound	No	Yes

ALLERY/IMMUNOLOGIC

Environmental allergies	No	Yes
Food allergies	No	Yes
Immunocompromised	No	Yes

NEUROLOGICAL

Dizziness	No	Yes
Facial asymmetry	No	Yes
Headaches	No	Yes
Light-headedness	No	Yes
Numbness	No	Yes
Seizures	No	Yes
Speech difficulty	No	Yes
Syncope / fainting	No	Yes
Tremors	No	Yes
Weakness	No	Yes

HEMATOLOGICAL

Adenopathy / swollen lymphnodes	No	Yes
Bruises/bleeds easily	No	Yes

PSYCHIATRIC

Agitation	No	Yes
Behavior Problem	No	Yes
Confusion	No	Yes
Decreased Concentration	No	Yes
Dysphoric mood / depressed	No	Yes
Hallucinations	No	Yes
Hyperactive	No	Yes
Nervous/anxious	No	Yes
Self-injury	No	Yes
Sleep disturbance	No	Yes
Suicidal ideas	No	Yes