DATE _____ PATIENT NAME: _____ Date of Birth_____

REVIEW OF SYSTEMS

(Please complete the following and check any of the following that you have or have concerns about)

Constitutional	☐	Fever, chills	**Urology**	☐	Difficulty urinating
	☐	Fatigue		☐	Frequent urination
	☐	Weight Gain/Weight Loss		☐	Night time urination
	☐	Increased Appetite		☐	Incontinence
	☐	Reduced Appetite		☐	Pain with urination
	☐	Sweats			
	☐	Sleep Problems			
EYE	☐	Vision Problem	**Musculoskeletal**	☐	Joint pain
	☐	Diminished vision		☐	Joint swelling
	☐	Eye pain		☐	Joint Stiffness
	☐	Redness		☐	Back pain
	☐	Irritation		☐	Neck pain
ENT	☐	Nasal congestion	**Neurology**	☐	Headache
	☐	Runny nose		☐	Migraines
	☐	Nosebleeds		☐	Passing Out
	☐	Facial or sinus pain		☐	Confusion
	☐	Sores in mouth		☐	Seizures
	☐	Dental problems		☐	Weakness
	☐	Voice changes		☐	Difficulty Speaking
	☐	Ear discomfort		☐	Difficulty Walking
	☐	Hearing problems		☐	Off balance
	☐	Snoring			
Respiratory	☐	Cough	**Dermatology**	☐	Rash
	☐	Excess phlegm production		☐	Worrisome moles
	☐	Shortness of breath		☐	Skin lesions
	☐	Wheezing			
	☐	Stop breathing when asleep (apnea episode)			
Cardiovascular	☐	Chest pain	**Mental Health**	☐	Sadness
	☐	Leg pain		☐	Anxious
	☐	Leg swelling		☐	Do you feel unsafe?
	☐	Palpitations (racing heart or skipped beats)		☐	Increased stress
				☐	Chemical dependency
	☐	Decrease in exercise ability		☐	Other Addictions
Gastroenterology	☐	Difficulty swallowing	**Endocrinology**	☐	Cold intolerance
	☐	Heartburn		☐	Heat intolerance
	☐	Abdominal pain		☐	Frequently thirsty
	☐	Nausea		☐	Frequent urination
	☐	Vomiting		☐	Loss of height
	☐	Diarrhea			
	☐	Constipation			
	☐	Blood in stools			
	☐	Hemorrhoids			
	☐	Jaundice			
Male Reproductive	☐	Sexually Transmitted Disease concern	**Hematology--Oncology**	☐	Swollen Glands
	☐	Penile discharge		☐	Varicose Veins
	☐	Penile lesions		☐	Easy Bruising
	☐	Testicular lump			
	☐	Testicular pain			
	☐	Difficulty with erection			
	☐	Diminished sexual drive			
Female Reproductive	☐	Breast lumps	**Additional Information**		<u>I have a living will</u>
	☐	Breast pain		☐	Yes
	☐	Nipple discharge		☐	No
	☐	Sexually Transmitted Disease concern			<u>I am an organ donor</u>
	☐	Heavy periods		☐	Yes
	☐	Abnormal vaginal discharge		☐	No
	☐	Abnormal pap smear			<u>I am interested in discussing:</u>
	☐	Painful intercourse		☐	A living will
	☐	Irregular periods		☐	Organ donation
	☐	Contraceptive needs			