

REVIEW OF SYSTEMS

NAME (Please Print) _____

SIGNATURE _____

DATE _____

1) Constitutional:

- Fever
- Weight loss
- Other

2) Eyes:

- Blurred vision
- Double vision
- Pain
- Discharge
- Other

3) Ears, Nose, Mouth, Throat:

- Pain
- Mass
- Discharge
- Hearing loss
- Smell
- Other

4) Cardiovascular:

- Chest Pain
- Shortness of Breath on exertion
- Irregular heartbeat
- Other

5) Respiratory:

- Shortness of Breath
- Cough
- Asthma
- Other

6) Gastrointestinal:

- Bowel habits/change
- Diarrhea
- Constipation
- Stomach pain
- Ulcers
- Other

7) Hematologic/Lymphatic:

- Anemia
- Blood disease
- Free bleeder
- Swollen lymph nodes

- | | | |
|--|---------------------------------|--------------------------|
| | Other | <input type="checkbox"/> |
| 8) <u>Musculoskeletal:</u> | | |
| | Weakness | <input type="checkbox"/> |
| | Joint pain | <input type="checkbox"/> |
| | Decreased range of motion (ROM) | <input type="checkbox"/> |
| | Other | <input type="checkbox"/> |
| 9) <u>Integumentary (Skin/Breast):</u> | | |
| | Masses | <input type="checkbox"/> |
| | Tumors | <input type="checkbox"/> |
| | Pigmented lesions | <input type="checkbox"/> |
| | Rash | <input type="checkbox"/> |
| | Other | <input type="checkbox"/> |
| 10) <u>Neurologic:</u> | | |
| | Weakness | <input type="checkbox"/> |
| | Tingling | <input type="checkbox"/> |
| | Numbness | <input type="checkbox"/> |
| | Other | <input type="checkbox"/> |