Review of Systems

Please indicate whether you are experiencing any of the following symptoms:

Constitutional

____Yes ____No Chills	____Yes ____No Weight Gain	____Yes ____No Weakness
____Yes ____No Fatigue	____Yes ____No Weight Loss	____Yes ____No Irritability
____Yes ____No Fever	____Yes ____No Night Sweats	

HEENT

____Yes ____No Headache	____Yes ____No Facial Pain	____Yes ____No Hoarseness
____Yes ____No Loss of Vision	____Yes ____No Nasal Congestion	____Yes ____No Blurred Vision
____Yes ____No Hearing Loss	____Yes ____No Double Vision	____Yes ____No Fever

Respiratory

____Yes ____No Coughing	____Yes ____No Short of Breath	____Yes ____No Breathing Hurts
____Yes ____No Snoring	____Yes ____No Wheezing	____Yes ____No TB Exposure

Cardiovascular

____Yes ____No Chest Pain	____Yes ____No Leg Swelling	____Yes ____No Claudication
____Yes ____No Edema	____Yes ____No Fainting	____Yes ____No Palpitations

Gastrointestinal

____Yes ____No Constipation	____Yes ____No Vomiting	____Yes ____No Heartburn
____Yes ____No Diarrhea	____Yes ____No Decreased Appetite	____Yes ____No Hemorrhoids
____Yes ____No Nausea	____Yes ____No Reflux	____Yes ____No Rectal Bleeding

Genitourinary

____Yes ____No Back Pain	____Yes ____No Decreased Urine Output	____Yes ____No Painful Urination
____Yes ____No Frequent Urination	____Yes ____No Change in Urine Color	____Yes ____No Stone Passage
____Yes ____No Urinary Incontinence	____Yes ____No Mass in Groin	____Yes ____No Blood in Urine

Metabolic

____Yes ____No Hair Loss
____Yes ____No Heat Intolerance
____Yes ____No Uncontrolled Hunger
____Yes ____No Change in Sleep Patterns
____Yes ____No Tremors
____Yes ____No Cold Intolerance

Neurological

____Yes ____No Memory Impairment
____Yes ____No Visual Changes
____Yes ____No Vertigo
____Yes ____No Seizures
____Yes ____No Loss of Consciousness
____Yes ____No Light-headed

Dermatologic

____Yes ____No Acne
____Yes ____No Skin Lesion
____Yes ____No Skin Irritation
____Yes ____No Rash
____Yes ____No Severe Itching

Musculoskeletal

____Yes ____No Back Pain
____Yes ____No Joint Swelling
____Yes ____No Neck Pain
____Yes ____No Joint Pain
____Yes ____No Muscle Weakness

Hematologic/Lymphatic

____Yes ____No Easy Bleeding
____Yes ____No Easy Bruising

Immunologic

____Yes ____No Contact Allergy
____Yes ____No Food Allergies
____Yes ____No Seasonal Allergies
____Yes ____No Environmental Allergies

Reproductive

____Yes ____No Vaginal Discharge
____Yes ____No Hot Flashes
____Yes ____No Abnormal Pap
____Yes ____No Breast Discharge