Name: DOB: Today's Date

REVIEW OF SYSTEMS

Are you in any pain? yes / no Where? _____ With 10 being the worst, what is your pain level from 1-10? ____
Are you taking any pain medication? yes / no What is the name and how often are you taking it?_____

Are you tired? Yes / no With 10 being the worst, what is your fatigue level? _____

Are you having any… Fever yes / no Chills yes / no Sweating yes / no Anorexia yes / no
Weight Loss yes / no Sleep Disturbance yes / no

Eyes: Any… Blurred Vision yes / no Double Vision yes / no Floaters yes / no
Redness yes / no Discharge yes / no Decreased Visual Activity yes / no

Ears, Nose, Mouth and Throat: Any… Hearing Loss yes / no Altered Smell yes / no
Altered Taste yes / no Mouth Sores yes / no Dry Mouth yes / no
Difficulty in Swallowing yes / no

Heart: Any… Chest Pain yes / no Palpitations yes / no Difficulty Breathing yes / no
Difficult breathing while laying down (Orthopnea-PND) yes / no Lethargic yes / no
Swelling (Edema) yes / no Varicose Veins yes / no

Respiratory: Any… Trouble breathing while resting yes / no Trouble breathing on exertion yes /no Wheezing yes /no Cough yes /no Noisy Breathing (Stridor) yes/no
Coughing up blood (Hemoptysis) yes / no

Gastrointestinal: Any… nausea yes / no vomiting yes / no diarrhea yes / no
Constipation yes / no heartburn yes / no abdominal pain yes / no
Black stools yes / no Blood in stools yes / no Unable to control bowels yes / no

Urinary: Any… difficulty/painful urination yes / no urination at night yes / no urgency of urination yes / no leaking of urine yes / no reduced urination yes / no
Blood in urine yes / no Unable to control urination yes / no

Musculoskeletal: Any… Bone pain yes / no Pain in muscles yes / no Pain in a joint yes / no
Which? _____ Back pain yes / no Swelling in joint yes /no Which? _____
Limited Range of Motion yes / no

Skin: Any… Rash yes / no Itching yes / no Lesions yes / no Where? _____

Breast Exam: Any… Mass yes / no Tenderness yes / no Nipple discharge yes / no

Neurological: Any… Weakness yes / no Paralysis yes / no Where? _____ Numbness yes / no Where? _____ Tingling yes / no Where? _____ Tremor yes / no Headache yes / no Altered consciousness yes / no Seizures yes / no

Psychiatric: Any… Nervousness yes / no Stress yes / no Depression yes / no
Memory Loss yes / no Confusion yes / no Hallucinations/Delusions yes / no

Endocrine: Any… Heat intolerance yes / no Cold intolerance yes / no Excessive Sweating yes / no
Abnormal thirst yes / no Excessive urination yes / no Change in glove or shoe size yes / no

Hematologic/Lymphatic: Any… excessive or spontaneous bleeding yes / no Enlarged lymph nodes yes

Allergic/Immunologic: Any… frequent or severe infections yes / no Allergic reactions yes / no What happened? _____