# Review of Systems

Please answer every question

**Marking Instructions**
Please use a #2 pencil
Fill in the complete oval as shown...

Please mark only the symptoms you CURRENTLY are experiencing.
Mark all that apply ---- if no symptoms, please mark “NONE”

- **General**
  - fatigue
  - weight loss
  - weight gain
  - fever
  - persistent infections

- **Eyes**
  - visual disturbances
  - glasses / contacts

- **Ear, Nose, and Throat**
  - hearing loss
  - sinus pain
  - seasonal allergies
  - oral ulcers

- **Cardiovascular**
  - difficulty breathing on exertions
  - chest pain
  - palpitations
  - swelling hands / feet

- **Respiratory**
  - wheezing
  - difficulty breathing
  - chronic cough
  - coughing blood

- **Breast**
  - mass / lump
  - breast pain
  - nipple discharge

- **Gastrointestinal**
  - nausea
  - constipation
  - chronic diarrhea
  - abdominal pain
  - jaundice
  - excessive gas
  - heartburn

- **Female Genitourinary (Women Only)**
  - pelvic pain
  - urinary frequency
  - urinary urgency
  - excessive urination at night
  - vaginal dryness
  - vaginal discharge
  - vaginal itch or burning
  - painful intercourse
  - blood in urine
  - painful urination
  - painful menstruation
  - menstrual irregularities
  - urine leakage

- **Male Genitourinary (Men Only)**
  - urine leakage
  - urinary frequency
  - urinary urgency
  - excessive urination at night
  - urinary mass
  - testicular pain
  - penile lesions
  - blood in urine

- **Musculoskeletal**
  - joint pain
  - muscle pain
  - muscle weakness

- **Skin**
  - dry skin
  - rash
  - new sore / lesion
  - skin ulcer

- **Neurologic**
  - fainting
  - decreased memory
  - numbness
  - trouble walking
  - seizures
  - headaches

- **Psychiatric**
  - anxiety
  - depression
  - frequent crying
  - fearful

- **Endocrine**
  - hair changes
  - heat intolerance
  - cold intolerance
  - hot flashes

- **Heme/Lymphatic**
  - easy bruising
  - excessive bleeding
  - gland problems

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