

# Review of Systems

**Check Any That Apply**

<i>Do you have any of these <b>OVERALL CONDITIONS?</b></i>		<i>Are you having problems with <b>EARS, NOSE, OR THROAT?</b></i>		<i>Are you having any <b>HEART-RELATED ISSUES?</b></i>	
Unable to transfer	<input type="checkbox"/>	Cold/Flu	<input type="checkbox"/>	Heart attack	<input type="checkbox"/>
Unable to walk without assistance	<input type="checkbox"/>	Loose teeth or wear dentures	<input type="checkbox"/>	Heart murmur	<input type="checkbox"/>
Unable to lie flat	<input type="checkbox"/>	Earaches	<input type="checkbox"/>	Pacemaker	<input type="checkbox"/>
Use supplemental oxygen	<input type="checkbox"/>	Hearing loss	<input type="checkbox"/>	Palpitations/fluttering	<input type="checkbox"/>
Other special needs (note below)	<input type="checkbox"/>	Ringing in the ears	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	Sinus problems	<input type="checkbox"/>	Rapid heart rate	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	Nasal congestion	<input type="checkbox"/>	Irregular heart rhythm	<input type="checkbox"/>
Weakness	<input type="checkbox"/>	Sore throat	<input type="checkbox"/>	Chest pain or pressure	<input type="checkbox"/>
Insomnia	<input type="checkbox"/>	Hoarseness	<input type="checkbox"/>	Shortness of breath	<input type="checkbox"/>
Weight gain/loss	<input type="checkbox"/>	Vertigo	<input type="checkbox"/>	Swelling hands, feet, ankles	<input type="checkbox"/>
Pregnant or possibly pregnant	<input type="checkbox"/>	Recurrent nose bleeds	<input type="checkbox"/>		
Night sweats	<input type="checkbox"/>	Difficulty swallowing	<input type="checkbox"/>		
Nursing a child	<input type="checkbox"/>		<input type="checkbox"/>		

<i>Are you having any <b>RESPIRATORY PROBLEMS?</b></i>		<i>Are you having any <b>INTESTINAL PROBLEMS?</b></i>		<i>Are you having any <b>GENITAL/URINARY PROBLEMS?</b></i>	
Coughing Blood	<input type="checkbox"/>	Blood in Stools	<input type="checkbox"/>	Prostate problems	<input type="checkbox"/>
Chronic Cough	<input type="checkbox"/>	Stomach Pain	<input type="checkbox"/>	Frequent urination	<input type="checkbox"/>
Shortness of Breath	<input type="checkbox"/>	Black Tarry Stools	<input type="checkbox"/>	Blood in urine	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	Pain with urination	<input type="checkbox"/>
Bronchitis	<input type="checkbox"/>	Decreased Appetite	<input type="checkbox"/>	Urinary discharge	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	Genital sores	<input type="checkbox"/>
Pneumonia	<input type="checkbox"/>	Food Intolerance	<input type="checkbox"/>	Abnormal menstruation	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	Heartburn	<input type="checkbox"/>		
		Jaundice	<input type="checkbox"/>		
		Nausea	<input type="checkbox"/>		
		Vomiting	<input type="checkbox"/>		

<i>Are you having any <b>SKIN PROBLEMS?</b></i>		<i>Are you having any <b>ENDOCRINE PROBLEMS?</b></i>		<i>Are you having any <b>NEUROLOGIC PROBLEMS?</b></i>	
Skin rash	<input type="checkbox"/>	Enlarged glands in neck	<input type="checkbox"/>	Dementia	<input type="checkbox"/>
Abnormal lesions	<input type="checkbox"/>	Bulging eyes	<input type="checkbox"/>	Involuntary movements	<input type="checkbox"/>
Hives	<input type="checkbox"/>	Heat or cold intolerance	<input type="checkbox"/>	Balance problems	<input type="checkbox"/>
Sores	<input type="checkbox"/>	Increased thirst	<input type="checkbox"/>	Vertigo	<input type="checkbox"/>
		Increased urination	<input type="checkbox"/>	Fainting	<input type="checkbox"/>
				Memory problems	<input type="checkbox"/>
				Numbness of extremities	<input type="checkbox"/>
				Seizures	<input type="checkbox"/>
				Tingling	<input type="checkbox"/>
				Tremors	<input type="checkbox"/>

<i>Are you having any <b>MENTAL HEALTH PROBLEMS?</b></i>		<i>Are you having any <b>MUSCULOSKELETAL PROBLEMS?</b></i>		<i>Are you having any <b>HEMATOLOGIC PROBLEMS?</b></i>	
Depression	<input type="checkbox"/>	Joint pain/stiffness/redness	<input type="checkbox"/>	Enlarged lymph nodes	<input type="checkbox"/>
Nervousness	<input type="checkbox"/>	Back pain	<input type="checkbox"/>	Tender lymph nodes	<input type="checkbox"/>
Tension/Irritability	<input type="checkbox"/>	Muscle pain	<input type="checkbox"/>	Easy bleeding or bruising	<input type="checkbox"/>
Excessively elevated mood	<input type="checkbox"/>	Muscle wasting	<input type="checkbox"/>	Blood transfusion	<input type="checkbox"/>
Hallucinations	<input type="checkbox"/>	Easily broken bones	<input type="checkbox"/>		

**COMMENTS:** \_\_\_\_\_

**NAME:** \_\_\_\_\_ **DOB:** \_\_\_\_\_ **SIGNATURE:** \_\_\_\_\_