

REVIEW OF SYSTEMS

PATIENT NAME: _____ DOB _____

- Have you been seen in the ER, Urgent Care or been hospitalized since your last visit?
- If so, where? _____
- Please mark any symptoms that you are having now or have had in the past 2 weeks.

Constitutional

- Fever
- Chills
- Poor appetite
- Weight Loss
- Weight Gain
- Exercise Regularly

Neurological

- Headaches
- Fainting
- Numbness in feet or legs

Genitourinary

- Burning with urination
- Blood in urine
- Foamy urine
- Trouble holding urine
- Waking up at night to urinate
- Difficulty emptying bladder

Gastrointestinal

- Abdominal pain
- Nausea
- Vomiting
- Diarrhea
- Constipation
- Heartburn

Endocrinology

- Hot flashes
- Thirsty all the time
- Controlled diabetes
- Uncontrolled diabetes

Pulmonary

- Cough
- Shortness of breath
- Wheezing

HEENT

- Eye/Vision Problems
- Nosebleeds
- Dry mouth
- Change in taste
- Hearing Changes

Psychological

- Anxiety
- Depression
- Problems with memory
- Trouble sleeping

Cardiovascular

- Chest pain or pressure
- Irregular heart beat or palpitations
- Pain in legs when walking
- Swelling in legs or feet

Musculoskeletal

- Back pain
- Joint pain or swelling
- Leg cramps

Skin

- Rash
- Itching

Hematology

- Easy bruising
- Bleeding gums

Anything else you would like your physician/NP to know?