Name:_____

Review of Systems

Check if you have had any of the following:

1. General: ___unexplained weight gain or loss ___weakness/fatigue___nightsweats___chills

2. Skin: ___new rash

3. Head/Eyes/Ears/Throat: ___vision loss___dizziness___hearing loss___hoarseness

4. Neck: ___enlarged lymph nodes___pain with neck movement

5. Breast:___lump___pain___discharge

6. Cardiopulmonary:___chest pain___short of breath___palpitations___wheezing___coughing blood

7. GI:___change in bowel habits___vomiting___blood in stool

8. GU:___incontinence___erectile dysfunction___frequent urination___pain with urination

9. Musculoskeletal:___joint pain___swollen joints___broken bone

10. Nervous System:___stroke___seizures___tremor

11. Blood:___anemia___clotting disorder

12. Endocrine:___diabets___thyroid problems