

Patient Name: \_\_\_\_\_

Please Print

Date of Birth: \_\_\_\_\_ Chart # \_\_\_\_\_

**REVIEW OF SYSTEMS:**

Please check any of the following symptoms that apply to your current health:

**GENERAL:**

- I tire easily
- I have a fever
- I have recent weight loss
- I have recent weight gain
- I have night sweats

**HEENT:**

- I have glaucoma
- I have cataracts
- I wear glasses or contacts
- I have a mass in my neck
- I have neck pain
- I have neck stiffness
- I have swollen glands in my neck
- I have frequent nosebleeds
- I have seasonal allergies
- I have nasal drainage
- I have ringing in my ears
- I have hearing loss
- I have ear pain
- I have bleeding gums
- I have dentures or plates
- I have a hoarse voice
- I have loose teeth

**HEM/ENDOCRINE:**

- I have diabetes
- I have thyroid disease
- I have a bleeding disorder
- I have anemia
- I have HIV
- I bruise easily
- I have had blood clots

**CARDIAC:**

- I have chest pains
- I have palpitations
- I have a heart murmur(s)
- I have an irregular heartbeat
- I have swelling in my legs
- I have heart failure
- I have high blood pressure

**RESPIRATORY:**

- I have shortness of breath
- I have a cough
- I have a productive cough
- I have frequent wheezing
- I have asthma

**GI/GU:**

- I have a mass in my belly
- I have belly pain
- I have bleeding ulcers
- I have heartburn regularly
- I have troubles swallowing
- I have frequent nausea and vomiting
- I have diarrhea
- I have constipation
- I have blood in my stool
- I have changes in my bowel habits
- I have kidney disease
- I have painful urination
- I have incontinence of the bowel  
and/or bladder
- I have a hernia
- I have hepatitis

**MUSCULOSKELETAL:**

- My joints are stiff
- My joints hurt
- My joints are swollen
- My muscles are smaller
- My muscles hurt
- My muscles are weak
- I have gout
- I have rheumatoid arthritis

**INTEGUMENT:**

- I have a rash
- I am being treated for a skin disorder

**NEUROLOGICAL:**

- I have decreased memory
- I have dizziness
- I have frequent headaches
- I have seizures
- I have a tremor
- I have numbness and tingling
- I faint frequently

**MENTAL HEALTH:**

- My sleep habits have changed
- I am anxious
- I am depressed
- I have difficulty concentrating
- I have difficulty sleeping
- I have hallucinations
- I have frequent mood swings
- I currently see a counselor