

Review of Systems

Check if you currently have or recently have had any of the following problems or concerns

GENERAL	CV (HEART)	o Vomiting	GU (URINARY MALE)
<input type="checkbox"/> Fever	<input type="checkbox"/> Difficulty breathing	<input type="checkbox"/> Yellowish skin color	<input type="checkbox"/> Dysuria
<input type="checkbox"/> Chills	<input type="checkbox"/> Near fainting	<input type="checkbox"/> Gas	<input type="checkbox"/> Hematuria
<input type="checkbox"/> Sweats	<input type="checkbox"/> Chest pain of discomfort	<input type="checkbox"/> Abdominal pain	<input type="checkbox"/> Discharge
<input type="checkbox"/> Anorexia	<input type="checkbox"/> Racing/skipping heart beats	<input type="checkbox"/> Abdominal bloating	<input type="checkbox"/> Urinary frequency
<input type="checkbox"/> Fatigue	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Hemorrhoids	<input type="checkbox"/> Urinary urgency
<input type="checkbox"/> Weakness	<input type="checkbox"/> Lightheadedness	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Blood in urine
<input type="checkbox"/> Malaise	<input type="checkbox"/> Shortness of breath with exertion	<input type="checkbox"/> Change in bowel habits	<input type="checkbox"/> Inability to empty bladder
<input type="checkbox"/> Weight Loss	<input type="checkbox"/> Palpitations	<input type="checkbox"/> Constipation	<input type="checkbox"/> Kidney pain
<input type="checkbox"/> Sleep Disorder	<input type="checkbox"/> Swelling of hands/feet	<input type="checkbox"/> Dark tarry stools	<input type="checkbox"/> Trouble starting urinary stream
EYES	<input type="checkbox"/> Difficulty breathing while laying down	<input type="checkbox"/> Bloody stools	<input type="checkbox"/> Painful urination
<input type="checkbox"/> Vision loss-1 eye	<input type="checkbox"/> Fainting	GU (URINARY FEMALE)	<input type="checkbox"/> Inability to control bladder
<input type="checkbox"/> Double Vision	<input type="checkbox"/> Leg cramps with exertion	<input type="checkbox"/> Foul urinary discharge	<input type="checkbox"/> Unusual urinary color
<input type="checkbox"/> Eye irritation	<input type="checkbox"/> Blush discoloration of lips or nails	<input type="checkbox"/> Blood in urine	<input type="checkbox"/> Nocturia
<input type="checkbox"/> Vision loss-both eyes	<input type="checkbox"/> Weight gain	<input type="checkbox"/> Urinary frequency	<input type="checkbox"/> Incontinence
<input type="checkbox"/> Blurring	RESP (LUNGS)	<input type="checkbox"/> Inability to empty bladder	<input type="checkbox"/> Genital sores
<input type="checkbox"/> Eye pain	<input type="checkbox"/> Sleep disturbance due to breathing	<input type="checkbox"/> Urinary urgency	<input type="checkbox"/> Decreased libido
<input type="checkbox"/> Halos	<input type="checkbox"/> Cough	<input type="checkbox"/> Kidney pain	<input type="checkbox"/> Erectile dysfunction
<input type="checkbox"/> Discharge	<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Trouble starting urinary stream	MUSCLES AND JOINTS
<input type="checkbox"/> Light sensitivity	<input type="checkbox"/> Coughing up blood	<input type="checkbox"/> Painful urination	<input type="checkbox"/> Muscle cramps
ENT	<input type="checkbox"/> Chest discomfort	<input type="checkbox"/> Night time urination	<input type="checkbox"/> Joint pain
<input type="checkbox"/> Ringing in ears	<input type="checkbox"/> Wheezing	<input type="checkbox"/> Inability to control bladder	<input type="checkbox"/> Joint swelling
<input type="checkbox"/> Ear discharge	<input type="checkbox"/> Excessive sputum	<input type="checkbox"/> Genital sores	<input type="checkbox"/> Presence of joint fluid
<input type="checkbox"/> Earache	<input type="checkbox"/> Excessive snoring	<input type="checkbox"/> Lack of sexual drive	<input type="checkbox"/> Back pain
<input type="checkbox"/> Decreased hearing	GI	<input type="checkbox"/> Excessive heavy periods	<input type="checkbox"/> Stiffness
<input type="checkbox"/> Nasal congestion	<input type="checkbox"/> Excessive appetite	<input type="checkbox"/> Missed periods	<input type="checkbox"/> Muscle weakness
<input type="checkbox"/> Nosebleeds	<input type="checkbox"/> Loss of appetite	<input type="checkbox"/> Unusual urinary color	<input type="checkbox"/> Arthritis
<input type="checkbox"/> Difficulty swallowing	<input type="checkbox"/> Indigestion	<input type="checkbox"/> Other abnormal vaginal bleeding	<input type="checkbox"/> Gout
<input type="checkbox"/> Hoarseness	<input type="checkbox"/> Vomiting blood	<input type="checkbox"/> Pelvic pain	<input type="checkbox"/> Loss of strength
<input type="checkbox"/> Sore throat	<input type="checkbox"/> Nausea		<input type="checkbox"/> Muscles aches

Continued Review of Systems

SKIN	○ Memory loss		
○ Excessive perspiration	PSYCHIATRY		
○ Night sweats	○ Sense of great danger		
○ Suspicious lesions	○ Anxiety		
○ Change in nail beds	○ Thoughts of suicide		
○ Dryness	○ Mental problems		
○ Poor wound healing	○ Depression		
○ Unusual hair distribution	○ Thoughts of violence		
○ Skin cancer	○ Frightening visions or sound		
○ Itching	ENDOCRINOLOGY		
○ Changes in color of skin	○ Excessive hunger		
○ Flushing	○ Cold intolerance		
○ Rash	○ Heat intolerance		
NEUROLOGY	○ Excessive urination		
○ Difficulty with concentration	○ Excessive thirst		
○ Poor balance	○ Weight change		
○ Headaches	HEMATOLOGY		
○ Disturbances in coordination	○ Enlarge lymph nodes		
○ Numbness	○ Bleeding		
○ Inability to speak	○ Skin discoloration		
○ Falling down	○ Abnormal bruising		
○ Tingling	○ Fevers		
○ Brief paralysis	ALLERGY		
○ Visual disturbances	○ Persistent infections		
○ Seizures	○ Hives or rash		
○ Weakness	○ Seasonal allergies		
○ Sensation of room spinning	○ HIV exposure		
○ Tremors			
○ Fainting			
○ Excessive daytime sleeping			