Patient: _____ Date: ___/___/_____

Review of Systems

HEAD
Headaches
Eye pain/sensitivity to light
Change in vision/blurred/double vision
Nose pain/problems/bleeding
Sinus pain/pressure/hay fever/allergies
Ear pain/hearing loss/ringing in ears
Dizziness/fainting/seizures
Lumps/bumps/sores in mouth or on tongue
NECK
Throat pain/soreness/difficulty swallowing
Lumps/bumps/sores in neck/throat
Neck stiff or sore
CHEST
Cough/congestion - coughing anything up
Lung disease
Asthma/emphysema/bronchitis
Pneumonia/tuberculosis
Shortness of breath
Heart problems
Chest pain/pressure/discomfort/palpitations
High blood pressure/cholesterol
Diabetes/thyroid problems
BELLY
Belly pain/lumps/bumps
Nausea/vomiting/diarrhea/constipation
Pain/problems urinating/bowel movement
Blood in urine or stool
Need to get up at night to urinate
Flank or back pain
LIMBS
Arm/leg/joint pain
Arms/legs strong and equally strong
Arm/leg weakness/numbness/tingling
Loss of balance/falling
Swelling arms/legs/hands/feet
GENERAL
How have you been feeling last 3 days
Fever/chills/sweating/night sweats
Recent weight loss/gain
Appetite/eating/drinking ok
Sleeping ok - sleep through night/wake up
Anything not covered