Checklist: Review of Systems

Patient Name: _____
Date of Birth: _____
Patient Signature: _____
Date: _____

General-

Weight loss or gain	O YES O NO
Fatigue	O YES O NO
Fever or chills	O YES O NO
Weakness	O YES O NO
Trouble sleeping	O YES O NO

Skin-

Rashes	O YES O NO
Lumps	O YES O NO
Itching	O YES O NO
Dryness	O YES O NO
Color changes	O YES O NO
Hair and nail changes	O YES O NO

Head-

Headache	O YES O NO
Head injury	O YES O NO

Ears-

Decreased hearing	O YES O NO
Ringing in ears	O YES O NO
Earache	O YES O NO
Drainage	O YES O NO

Eyes-

Glasses or contacts	O YES O NO
Pain	O YES O NO
Redness	O YES O NO
Blurry/double vision	O YES O NO
Flashing lights	O YES O NO
Specks	O YES O NO
Glaucoma	O YES O NO

Nose-

Stuffiness	O YES O NO
Discharge	O YES O NO
Itching	O YES O NO
Hay fever	O YES O NO
Nosebleeds	O YES O NO
Sinus pain	O YES O NO

Throat-

Teeth	O YES O NO
Gums	O YES O NO
Bleeding	O YES O NO
Dentures	O YES O NO
Sore tongue	O YES O NO
Sore throat	O YES O NO
Hoarseness	O YES O NO
Thrush	O YES O NO
Non-healing sores	O YES O NO
Last dental exam	O YES O NO

Neck-

Lumps	O YES O NO
Swollen glands	O YES O NO
Pain	O YES O NO
Stiffness	O YES O NO

Breasts-

Lumps	O YES O NO
Pain	O YES O NO
Discharge	O YES O NO
Self-exams	O YES O NO

Respiratory-

Cough (dry/wet, productive)	O YES O NO
Sputum (color/amount)	O YES O NO
Coughing up blood(hemoptysis	O YES O NO
Shortness of breath (dyspnea)	O YES O NO
Wheezing	O YES O NO
Painful breathing	O YES O NO

Cardiovascular-

Chest pain or discomfort	O YES O NO
Tightness	O YES O NO
Palpitations	O YES O NO
Shortness of breath with activity (dyspnea)	O YES O NO
Difficulty breathing lying down (orthopnea)	O YES O NO
Swelling (edema)	O YES O NO
Sudden awakening from sleep with shortness of breath (Paroxysmal Nocturnal Dyspnea)	O YES O NO

Gastrointestinal-

Swallowing difficulties	O YES O NO
Heartburn	O YES O NO
Change in appetite	O YES O NO
Nausea	O YES O NO
Change in bowel habits	O YES O NO
Rectal bleeding	O YES O NO
Constipation	O YES O NO
Diarrhea	O YES O NO
Yellow eyes or skin (jaundice)	O YES O NO

Urinary-

Frequency	O YES O NO
Urgency	O YES O NO
Burning or pain	O YES O NO
Blood in urine(hematuria)	O YES O NO
Incontinence	O YES O NO
Change in urinary strength	O YES O NO

Genital-

Male-

Pain with sex	O YES O NO
Hernia	O YES O NO
Penile discharge	O YES O NO
Sores	O YES O NO
Masses or pain	O YES O NO
Erectile dysfunction	O YES O NO
STD's	O YES O NO

Female-

Pain with sex	O YES O NO
Vaginal dryness	O YES O NO
Hot flashes	O YES O NO
Vaginal discharge	O YES O NO
Itching or rash	O YES O NO
STD's	O YES O NO

Vascular-

Calf pain with walking	O YES O NO
(Claudication)	O YES O NO
Leg cramping	O YES O NO

Musculoskeletal-

Muscle or joint pain	O YES O NO
Stiffness	O YES O NO
Back pain	O YES O NO
Redness of joints	O YES O NO
Swelling of joints	O YES O NO
Trauma	O YES O NO

Neurologic-

Dizziness	O YES O NO
Fainting	O YES O NO
Seizures	O YES O NO
Weakness	O YES O NO
Numbness	O YES O NO
Tingling	O YES O NO
Tremor	O YES O NO

Hematologic-

Ease of bruising	O YES O NO
Ease of bleeding	O YES O NO

Endocrine-

Head or cold intolerance	O YES O NO
Sweating	O YES O NO
Frequent urination (polyuria)	O YES O NO
Thirst (polydypsia)	O YES O NO
Increased appetite(polyphagia)	O YES O NO

Psychiatric-

Nervousness	O YES O NO
Depression	O YES O NO
Memory loss	O YES O NO
Stress	O YES O NO
Trouble Sleeping	O YES O NO