Medical Review of Systems

Please indicate below if you have experienced any of these symptoms over the past 2 weeks:

General, constitutional
Good general health lately ☐ no ☐ yes
Recent weight change ☐ no ☐ yes
Fever ☐ no ☐ yes
Fatigue ☐ no ☐ yes

Eyes and vision
Wear glasses / contacts ☐ no ☐ yes
Blurred or double vision ☐ no ☐ yes
Glaucoma ☐ no ☐ yes
Eye disease or injury ☐ no ☐ yes

Ears, nose, throat
Ringing in the ears ☐ no ☐ yes
Earaches or drainage ☐ no ☐ yes
Sinus problems ☐ no ☐ yes
Nose bleeds ☐ no ☐ yes
Hearing loss ☐ no ☐ yes
Bleeding gums ☐ no ☐ yes
Bad breath or bad taste ☐ no ☐ yes
Sore throat /voice change ☐ no ☐ yes
Swollen glands in neck ☐ no ☐ yes
Mouth sores ☐ no ☐ yes

Gastrointestinal
Change in bowel movements ☐ no ☐ yes
Nausea or vomiting ☐ no ☐ yes
Frequent diarrhea ☐ no ☐ yes
Painful bowel movements ☐ no ☐ yes
Constipation ☐ no ☐ yes
Loss of appetite ☐ no ☐ yes
Stomach pain ☐ no ☐ yes
Blood in stool ☐ no ☐ yes

Heart and Cardiovascular
Chest pains ☐ no ☐ yes
Sudden heartbeat changes ☐ no ☐ yes
Swelling of extremities ☐ no ☐ yes
Heart trouble ☐ no ☐ yes

Musculoskeletal
Joint stiffness or swelling ☐ no ☐ yes
Muscles/joint weakness ☐ no ☐ yes
Muscle pain or cramps ☐ no ☐ yes
Joint or back pain ☐ no ☐ yes
Difficulty in walking ☐ no ☐ yes
Cold extremities ☐ no ☐ yes

Genitourinary
Sexual difficulty ☐ no ☐ yes
Kidney stones ☐ no ☐ yes
Burning/painful urination ☐ no ☐ yes
Blood in urine ☐ no ☐ yes
Strain with urination ☐ no ☐ yes
Incontinence or dribbling ☐ no ☐ yes
Frequent urination ☐ no ☐ yes
Vaginal discharge ☐ no ☐ yes
Irregular/painful periods ☐ no ☐ yes

Endocrine
Thyroid disease ☐ no ☐ yes
Diabetes ☐ no ☐ yes
Excessive thirst/urination ☐ no ☐ yes
Heat or cold intolerance ☐ no ☐ yes
Hormone problems ☐ no ☐ yes
Dry skin ☐ no ☐ yes
Change in hat or glove size ☐ no ☐ yes

Hematologic/Lymphatic
Easily bruise or bleed ☐ no ☐ yes
Anemia ☐ no ☐ yes
Swollen glands ☐ no ☐ yes
Transfusion ☐ no ☐ yes
Slow to heal after cuts ☐ no ☐ yes

Neurological
Stroke ☐ no ☐ yes
Light headed or dizzy ☐ no ☐ yes
Head injury ☐ no ☐ yes
Tremors ☐ no ☐ yes
Headaches ☐ no ☐ yes
Paralysis ☐ no ☐ yes
Convulsions or seizures ☐ no ☐ yes
Numbness or tingling ☐ no ☐ yes

Respiratory
Spitting up blood ☐ no ☐ yes
Shortness of breath ☐ no ☐ yes
Asthma or wheezing ☐ no ☐ yes
Frequent coughing ☐ no ☐ yes

Skin and breasts
Rash or itching ☐ no ☐ yes
Change in skin color ☐ no ☐ yes
Varicose veins ☐ no ☐ yes
Breast pain ☐ no ☐ yes
Breast lump ☐ no ☐ yes
Breast discharge ☐ no ☐ yes
Change in hair or nails ☐ no ☐ yes

Patient Name: ____________________

DOB: ______________ Gender: M F

Patient Signature: ________________

Date: _________________________

Physician Name: ____________________

Physician Signature: _________________

Date: ____________________________