



REVIEW OF SYSTEMS

1. <u>Constitutional Symptoms</u>							
Fever	No	Yes		Bloating	No	Yes	
Chills	No	Yes		Change in abdominal girth	No	Yes	
Weight loss	No	Yes		Diarrhea	No	Yes	
Weight gain	No	Yes		Constipation	No	Yes	
Fatigue	No	Yes		Abdominal pain	No	Yes	
Loss of appetite	No	Yes		Jaundice	No	Yes	
Body aches	No	Yes		Blood in stool	No	Yes	
Night sweats	No	Yes		Hemorrhoids	No	Yes	
2. <u>Breasts</u>				6. <u>Genitourinary</u>			
Lumps	No	Yes		Urgency	No	Yes	
Tenderness	No	Yes		Frequency	No	Yes	
Swelling	No	Yes		Painful urination	No	Yes	
Nipple discharge	No	Yes		Getting up at night to urinate	No	Yes	
3. <u>Cardiovascular</u>				Blood in urine	No	Yes	
Chest pain	No	Yes		Pus in urine	No	Yes	
Cardiac murmurs	No	Yes		Change in urine color	No	Yes	
Irregular heartbeats	No	Yes		Incontinence	No	Yes	
Rapid heart rate	No	Yes		Urinary retention	No	Yes	
Shortness of breath on exertion	No	Yes		Difficulty urinating	No	Yes	
Shortness of breath when lying down	No	Yes		Urinary hesitancy	No	Yes	
Feeling like you might pass out	No	Yes		Decreased stream	No	Yes	
Lower extremity swelling	No	Yes		Post-void dribbling	No	Yes	
Cramp/pain in legs when walking	No	Yes		Air/air bubbles in urine	No	Yes	
Rest pain	No	Yes		Decreased libido	No	Yes	
Lightheadedness	No	Yes		Increased libido	No	Yes	
4. <u>Respiratory</u>				Pain during intercourse	No	Yes	
Shortness of breath	No	Yes		Genital sores	No	Yes	
Wheezing	No	Yes		Hot flashes	No	Yes	
Cough	No	Yes		<i>Female:</i>			
Abnormal sputum	No	Yes		Irregular periods	No	Yes	
Coughing up blood	No	Yes		Painful periods	No	Yes	
Sleep apnea	No	Yes		Vaginal discharge	No	Yes	
Anesthetic problems	No	Yes		Possible pregnancy	No	Yes	
TB exposure	No	Yes		Absent periods	No	Yes	
5. <u>Gastrointestinal</u>				<i>Male:</i>			
Feeling full after eating a small amount	No	Yes		Erectile dysfunction	No	Yes	
Heartburn	No	Yes		Scrotal pain	No	Yes	
Vomiting blood	No	Yes		Scrotal mass	No	Yes	
Nausea	No	Yes		Penile discharge	No	Yes	
Vomiting	No	Yes		Blood in semen	No	Yes	
				Penile lesions	No	Yes	

Please complete other side.

7. **Skin**
- | | | |
|--|----|-----|
| Rash | No | Yes |
| Itching | No | Yes |
| New skin lesions | No | Yes |
| Pigmentation changes | No | Yes |
| Excessive hair growth in unusual locations | No | Yes |
8. **Neurologic**
- | | | |
|----------------------|----|-----|
| Tingling or numbness | No | Yes |
| Muscular weakness | No | Yes |
| Memory difficulties | No | Yes |
| Speech difficulties | No | Yes |
| Headache | No | Yes |
| Seizures | No | Yes |
| Tremors | No | Yes |
| Loss of balance | No | Yes |
9. **Musculoskeletal**
- | | | |
|----------------------|----|-----|
| Bone pain | No | Yes |
| Back pain | No | Yes |
| Joint pain | No | Yes |
| Muscle pain | No | Yes |
| Limitation of motion | No | Yes |
| Muscular weakness | No | Yes |
10. **Endocrine**
- | | | |
|------------------------------|----|-----|
| Excessive urination (volume) | No | Yes |
| Always thirsty | No | Yes |
| Central obesity | No | Yes |
11. **Psychiatric**
- | | | |
|---------------------|----|-----|
| Anxiety | No | Yes |
| Depression | No | Yes |
| Difficulty sleeping | No | Yes |
| Suicidal thoughts | No | Yes |
12. **Hematologic/Lymphatic**
- | | | |
|------------------------|----|-----|
| Easy bleeding | No | Yes |
| Bruise easily | No | Yes |
| Lymph node enlargement | No | Yes |
13. **Allergic-Immunologic**
- | | | |
|--------------------------------|----|-----|
| Sinus allergy symptoms | No | Yes |
| Skin allergy resulting in rash | No | Yes |

Signature: _____

Date: ____/____/____