Fill in the appropriate circles.

Name: _____ Date: _____

Review of Systems

Gastrointestinal:

O nausea O vomiting O abdominal pain O constipation
O diarrhea O blood in stool O heartburn O hemorrhoids
O incontinence of stool O no problems

General:

O fever O chills O sweats O weight gain
O weight loss O nasal congestion O hoarseness O dental problems
O nose bleeding O no problems

Genitourinary:

O pain/burning when urinating O blood in urine O increased frequency of urination
O incomplete voiding O incontinence of urine O menstruation irregularity
O menopause O pregnancy O irritable bowel syndrome
O no problems

Heart:

O chest pain O palpitations O racy heart O leg swelling
O pain when walking O no problems

Hematological:

O bleeding or clotting disturbance O no problems

Lungs:

O coughing O blood in cough O shortness of breath O no problems

Lymphatic:

O swollen lymph nodes O no problems

Muscle & Joints:

O muscle aches O joint pains O joint swelling O sprains
O cramps O no problems

Neurological:

O fits O faints O blackouts O pins & needles
O numbness O weakness O nervousness O anxiety
O depression O gait problems O tremors O shaking
O speech problems O swallowing problems O ringing & buzzing in the ears
O vision problems O hearing problems O neck pain O back pain
O memory problems O headache/migraine O cold feet O no problems

Sleep:

O lack of sleep O inability to fall asleep O inability to stay awake
O tiredness/sleepiness during the day O snoring at night O choking at night
O holding breath at night O acting on dreams at night O restless legs before sleeping
O funny/creepy crawly feelings in the legs before sleeping O CPAP machine O no problems