

Name: \_\_\_\_\_ Date: \_\_\_\_\_

**REVIEW OF SYSTEMS: CHECK ANY THAT HAVE OCCURRED  
WITHIN THE LAST SIX MONTHS**

**CONSTITUTIONAL**

- FEVERS
- WEIGHT LOSS
- NIGHT SWEATS
- FATIGUE
- LIGHTHEADEDNESS

**EYES/ENT**

- GLASSES/CONTACTS
- VISUAL CHANGES
- HEARING AIDS
- CHANGE IN HEARING
- NASAL DISCHARGE OR BLEEDING
- MOUTH, THROAT, OR TONGUE PAIN
- HOARSENESS OR VOICE CHANGE
- SWALLOWING PROBLEMS
- DENTAL PROBLEMS
- DENTURES
- DATE OF LAST DENTAL APPT \_\_\_\_\_

**CARDIOVASCULAR**

- HIGH BLOOD PRESSURE
- HIGH CHOLESTEROL
- CHEST PAIN OR ANGINA
- IRREGULAR HEART RHYTHM
- PALPITATIONS
- PRIOR HEART ATTACKS
- HEART SURGERY
- LEG SWELLING
- BLOOD CLOTS

**PULMONARY**

- ASTHMA
- BRONCHITIS
- EMPHYSEMA
- SHORTNESS OF BREATH
- PRODUCTIVE COUGH
- PAIN WITH DEEP BREATH
- BLOOD IN SPUTUM
- TUBERCULOSIS OR (+) TB TEST

**MALE REPRODUCTIVE**

- TESTICULAR LUMPS/PAIN/SWELLING
- PROSTATE PROBLEMS
- ELEVATED PSA TEST
- IMPOTENCE / ERECTILE DYSFUNCTION

**FEMALE REPRODUCTIVE**

- LAST MENSTRUAL PERIOD \_\_\_\_\_
- MENSTRUAL PROBLEMS
- POST-MENOPAUSAL BLEEDING
- PREGNANT
- BREAST LUMP OR DIMPLING
- NIPPLE DISCHARGE
- DATE OF LAST MAMMOGRAM \_\_\_\_\_

**MUSCULOSKELETAL**

- BACK PAIN OR INJURY
- ARTHRITIS
- FRACTURE OR SURGERY
- JOINT PROBLEM
- MUSCULOSKELETAL PAIN
- GOUT

**SKIN**

- RASH
- ITCHING
- CHANGING MOLES
- NON-HEALING AREAS

**NEUROLOGIC**

- NEUROLOGIC DISEASE OR INJURY
- ARM OR LEG WEAKNESS
- HISTORY OF FALLS
- TREMORS / SEIZURES
- DECREASED SENSATION
- HEADACHES
- CONFUSION / MEMORY LOSS
- LOSS OF CONSCIOUSNESS
- DIZZINESS OR VERTIGO

**PLEASE SEE OTHER SIDE**

