

# Review Of Systems

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

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

## General Info

Do you have trouble with your appetite?  Y  N

Have you had a weight change?  Y  N

Do you experience fevers or sweats?  Y  N

## Hematology

Do you bleed easily?  Y  N

Do you have swollen lymph nodes?  Y  N

Do you suffer from anemia?  Y  N

## Respiratory

Do you have a chronic cough?  Y  N

Do you experience wheezing?  Y  N

Do you ever cough up blood?  Y  N

## E.N.T. Skin

Have you ever had a skin cancer?  Y  N

Do you have pigmented skin lesions?  Y  N

Do you have any unusual rashes?  Y  N

## Cardiac

Do you have trouble breathing?  Y  N

Do you have tightness in your chest?  Y  N

Do your ankles swell?  Y  N

Do you have sinusitis?  Y  N

Do you have trouble with your hearing?  Y  N

Do you suffer from hoarseness?  Y  N

## Neurological

Are you troubled with headaches?  Y  N

Have you ever fainted?  Y  N

Do you have trouble with you vision?  Y  N

## Skeletal

Do you have fragile bones?  Y  N

Do you have weakness in your limbs?  Y  N

Do you suffer from arthritis?  Y  N

## Genito/Urinary

Do you urinate excessively at night?  Y  N

Have you passed dark or red urine?  Y  N

Have you ever had a kidney stone?  Y  N

## Mental Health

Do you feel anxious?  Y  N

Do you suffer from depression?  Y  N

Do you sometimes feel unstable?  Y  N

Reviewed by: \_\_\_\_\_ M.D. on \_\_\_\_\_