

## Review Of Systems

Please circle any problems you have had in the past.

### **General:**

Chills  
Unexplained night fever  
Night Sweats  
Marked Fatigue

### **Head:**

Headache  
Facial Pain  
Sinus Pain

### **Eyes:**

Blurred/Double Vision  
Light Sensitivity  
Eye Pain  
Eye Itching

### **Ears/Nose:**

Earache  
Hearing Loss  
Nose Bleeds  
Nasal Discharge  
Mouth Sores  
Bleeding Gums  
Hoarseness  
Throat Pain

### **Neck:**

Pain  
Stiffness  
Swelling

### **Breast:**

Pain  
Discharge  
Lump  
Biopsy  
Cancer

### **Heart:**

Heart Attack  
Chest Pain/Pressure  
Fast Heart Rate  
Palpitations

### **Lungs:**

Shortness of Breath  
Recurrent Cough  
Cough up Blood

Wheezing  
Asthma  
Sleep Apnea  
Snoring

### **Gastrointestinal:**

Difficulty Swallowing  
Heartburn  
Ulcers  
H. Pylori Treatment

Nausea

Vomiting  
Diarrhea  
Blood in Stool

Constipation

### **Urological:**

Difficult Urination  
Urinary Frequency  
Blood in Urine  
Pain with Urination  
Uncontrolled Urination  
Urinary Tract Infection

### **Skin:**

Itching  
Rashes  
Infections

### **Endocrine:**

Excessive Sweating  
Night Sweats  
Excessive Thirst  
Liver Disease  
Jaundice  
Cirrhosis  
High Cholesterol  
Hepatitis

Thyroid Problems

Diabetes

### **Skeletal:**

Joint Pain/Stiffness  
Muscle Aches  
Joint Swelling/Redness  
Gout  
Back Pain

### **Neurological:**

Dizziness  
Fainting  
Tremors  
Sensory Problems  
Seizures

### **Psychological:**

Anxiety  
Depression  
Insomnia  
Suicide Attempts  
Previous Abuse  
PTSD

### **Hematology:**

Enlarged Glands  
Bleeding Problems  
Early Bruising  
Lupus  
Connective Tissue Dz

### **Family History:**

Anesthesia Problems  
Bleeding Disorder  
Colon Cancer  
Breast Cancer  
Gastric Cancer  
Chrohn's Disease