

10-Point Review of Systems Template

Patient Name: _____ Date of Assessment: _____

Assessor: _____

Section 1: Constitutional		
Fever	<input type="checkbox"/> Present	<input type="checkbox"/> Absent
Chills	<input type="checkbox"/> Present	<input type="checkbox"/> Absent
Night sweats	<input type="checkbox"/> Present	<input type="checkbox"/> Absent
Weight loss	<input type="checkbox"/> Present	<input type="checkbox"/> Absent
Fatigue	<input type="checkbox"/> Present	<input type="checkbox"/> Absent
Section 2: HEENT		
Headache	<input type="checkbox"/> Present	<input type="checkbox"/> Absent
Dizziness	<input type="checkbox"/> Present	<input type="checkbox"/> Absent
Vision changes	<input type="checkbox"/> Present	<input type="checkbox"/> Absent
Hearing problems	<input type="checkbox"/> Present	<input type="checkbox"/> Absent
Sinus problems	<input type="checkbox"/> Present	<input type="checkbox"/> Absent
Sore throat	<input type="checkbox"/> Present	<input type="checkbox"/> Absent

Section 3: Respiratory		
Cough	<input type="checkbox"/> Present	<input type="checkbox"/> Absent
Shortness of breath	<input type="checkbox"/> Present	<input type="checkbox"/> Absent
Wheezing	<input type="checkbox"/> Present	<input type="checkbox"/> Absent
Chest pain	<input type="checkbox"/> Present	<input type="checkbox"/> Absent
Sputum production	<input type="checkbox"/> Present	<input type="checkbox"/> Absent
Hemoptysis	<input type="checkbox"/> Present	<input type="checkbox"/> Absent
Section 4: Cardiovascular		
Chest pain	<input type="checkbox"/> Present	<input type="checkbox"/> Absent
Palpitations	<input type="checkbox"/> Present	<input type="checkbox"/> Absent
Edema (swelling)	<input type="checkbox"/> Present	<input type="checkbox"/> Absent
Difficulty walking	<input type="checkbox"/> Present	<input type="checkbox"/> Absent
Hypertension	<input type="checkbox"/> Present	<input type="checkbox"/> Absent

Section 5: Gastrointestinal		
Abdominal pain	<input type="checkbox"/> Present	<input type="checkbox"/> Absent
Nausea	<input type="checkbox"/> Present	<input type="checkbox"/> Absent
Vomiting	<input type="checkbox"/> Present	<input type="checkbox"/> Absent
Diarrhea	<input type="checkbox"/> Present	<input type="checkbox"/> Absent
Constipation	<input type="checkbox"/> Present	<input type="checkbox"/> Absent
Changes in appetite	<input type="checkbox"/> Present	<input type="checkbox"/> Absent
Section 6: Genitourinary		
Urinary frequency	<input type="checkbox"/> Normal	<input type="checkbox"/> Increased <input type="checkbox"/> Decreased
Urinary urgency	<input type="checkbox"/> Present	<input type="checkbox"/> Absent
Urinary incontinence	<input type="checkbox"/> Present	<input type="checkbox"/> Absent
Dysuria (painful urination)	<input type="checkbox"/> Present	<input type="checkbox"/> Absent
Hematuria (blood in urine)	<input type="checkbox"/> Present	<input type="checkbox"/> Absent
Vaginal discharge	<input type="checkbox"/> Present	<input type="checkbox"/> Absent
Menstrual irregularities	<input type="checkbox"/> Present	<input type="checkbox"/> Absent

Section 7: Musculoskeletal		
Joint pain	<input type="checkbox"/> Present	<input type="checkbox"/> Absent
Stiffness	<input type="checkbox"/> Present	<input type="checkbox"/> Absent
Weakness	<input type="checkbox"/> Present	<input type="checkbox"/> Absent
Numbness	<input type="checkbox"/> Present	<input type="checkbox"/> Absent
Swelling	<input type="checkbox"/> Present	<input type="checkbox"/> Absent
Section 8: Neurological		
Headache	<input type="checkbox"/> Present	<input type="checkbox"/> Absent
Dizziness	<input type="checkbox"/> Present	<input type="checkbox"/> Absent
Weakness	<input type="checkbox"/> Present	<input type="checkbox"/> Absent
Numbness	<input type="checkbox"/> Present	<input type="checkbox"/> Absent
Changes in coordination	<input type="checkbox"/> Present	<input type="checkbox"/> Absent
Seizures	<input type="checkbox"/> Present	<input type="checkbox"/> Absent

Section 9: Psychiatric		
Mood changes	<input type="checkbox"/> Present	<input type="checkbox"/> Absent
Anxiety	<input type="checkbox"/> Present	<input type="checkbox"/> Absent
Depression	<input type="checkbox"/> Present	<input type="checkbox"/> Absent
Difficulty sleeping	<input type="checkbox"/> Present	<input type="checkbox"/> Absent
Suicidal thoughts	<input type="checkbox"/> Present	<input type="checkbox"/> Absent
Section 10: Integumentary		
Rashes	<input type="checkbox"/> Present	<input type="checkbox"/> Absent
Itching	<input type="checkbox"/> Present	<input type="checkbox"/> Absent
Moles or skin lesions	<input type="checkbox"/> Present	<input type="checkbox"/> Absent
Changes in skin color	<input type="checkbox"/> Present	<input type="checkbox"/> Absent
Hair loss	<input type="checkbox"/> Present	<input type="checkbox"/> Absent