

# Normal Review of Systems

Patient Information
Name:
Age:
Gender:
Date of Birth:
Date of Visit:

General	
<b>Constitutional</b>	<b>Skin</b>
<input type="checkbox"/> Fever <input type="checkbox"/> Weight loss <input type="checkbox"/> Fatigue	<input type="checkbox"/> Rashes <input type="checkbox"/> Lesions <input type="checkbox"/> Itching
<b>Head, Eyes, Ears, Nose, Throat (HEENT)</b>	
<b>Head</b>	<b>Eyes</b>
<input type="checkbox"/> Headaches <input type="checkbox"/> Trauma	<input type="checkbox"/> Vision changes <input type="checkbox"/> Eye pain <input type="checkbox"/> Double vision
<b>Ears</b>	<b>Nose</b>
<input type="checkbox"/> Hearing loss <input type="checkbox"/> Tinnitus <input type="checkbox"/> Ear pain	<input type="checkbox"/> Nasal congestion <input type="checkbox"/> Epistaxis
<b>Throat</b>	
<input type="checkbox"/> Sore throat <input type="checkbox"/> Dysphagia	

<b>Respiratory</b>	
<b>Nasal</b>	<b>Lungs</b>
<input type="checkbox"/> Rhinorrhea <input type="checkbox"/> Congestion	<input type="checkbox"/> Cough <input type="checkbox"/> Hemoptysis <input type="checkbox"/> Shortness of breath
<b>Chest</b>	
<input type="checkbox"/> Chest pain <input type="checkbox"/> Wheezing	
<b>Cardiovascular</b>	
<b>Heart</b>	<b>Vascular</b>
<input type="checkbox"/> Chest pain <input type="checkbox"/> Palpitations	<input type="checkbox"/> Edema <input type="checkbox"/> Claudication
<b>Gastrointestinal</b>	
<b>Mouth/Oral</b>	<b>Esophagus</b>
<input type="checkbox"/> Dental problems <input type="checkbox"/> Dysphagia	<input type="checkbox"/> Heartburn <input type="checkbox"/> Regurgitation
<b>Abdomen</b>	<b>Liver/Gallbladder</b>
<input type="checkbox"/> Abdominal pain <input type="checkbox"/> Bloating <input type="checkbox"/> Changes in bowel habits	<input type="checkbox"/> Jaundice <input type="checkbox"/> Right upper quadrant pain
<b>Pancreas</b>	
<input type="checkbox"/> Epigastric pain	

<b>Genitourinary</b>	
<b>Renal</b>	<b>Reproductive (Male/Female)</b>
Frequency: _____ Urgency: _____ <input type="checkbox"/> Hematuria	<input type="checkbox"/> Menstrual history <input type="checkbox"/> Erectile dysfunction
<b>Musculoskeletal</b>	
<b>Joints</b>	<b>Muscles</b>
<input type="checkbox"/> Arthralgia <input type="checkbox"/> Stiffness <input type="checkbox"/> Swelling	<input type="checkbox"/> Myalgia
<b>Neurological</b>	
<b>Headache</b>	<b>Seizures</b>
Type: _____ Frequency: _____ Severity: _____	Type: _____ Frequency: _____
<b>Mental Status</b>	
<input type="checkbox"/> Memory changes <input type="checkbox"/> Confusion	
<b>Psychiatric</b>	
<b>Mood</b>	<b>Sleep</b>
<input type="checkbox"/> Depression <input type="checkbox"/> Anxiety	<input type="checkbox"/> Insomnia <input type="checkbox"/> Hypersomnia
<b>Endocrine</b>	
<b>Thyroid</b>	<b>Diabetes</b>
<input type="checkbox"/> Changes in weight <input type="checkbox"/> Energy levels	<input type="checkbox"/> Polyuria <input type="checkbox"/> Polydipsia

