

Review of Systems List

Patient information	
Name	Age
Address	
Phone number	Email address:

Check the box for the condition/s that apply to your health.

Check here if none applied.

Constitutional	Skin
<input type="checkbox"/> Fever <input type="checkbox"/> Weight changes <input type="checkbox"/> Fatigue <input type="checkbox"/> Weakness <input type="checkbox"/> Night sweats	<input type="checkbox"/> Rashes <input type="checkbox"/> Lesions <input type="checkbox"/> Itching <input type="checkbox"/> Dryness <input type="checkbox"/> Changes in moles
Head, Eyes, Ears, Nose, and Throat (HEENT)	Respiratory
<input type="checkbox"/> Headaches <input type="checkbox"/> Vision changes <input type="checkbox"/> Ear pain <input type="checkbox"/> Nasal congestion <input type="checkbox"/> Sore throat <input type="checkbox"/> Dental problems	<input type="checkbox"/> Cough <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Wheezing <input type="checkbox"/> Chest pain with breathing <input type="checkbox"/> Sputum production

Cardiovascular	Gastrointestinal
<input type="checkbox"/> Chest pain <input type="checkbox"/> Palpitations <input type="checkbox"/> Edema (swelling) <input type="checkbox"/> Shortness of breath on exertion	<input type="checkbox"/> Abdominal pain <input type="checkbox"/> Nausea/vomiting <input type="checkbox"/> Diarrhea/constipation <input type="checkbox"/> Changes in bowel habits <input type="checkbox"/> Heartburn
Genitourinary	Musculoskeletal
<input type="checkbox"/> Dysuria (painful urination) <input type="checkbox"/> Frequency/urgency <input type="checkbox"/> Blood in urine <input type="checkbox"/> Changes in urinary habits <input type="checkbox"/> Sexual dysfunction	<input type="checkbox"/> Joint pain <input type="checkbox"/> Muscle pain <input type="checkbox"/> Stiffness <input type="checkbox"/> Swelling <input type="checkbox"/> Limited range of motion
Neurological	Psychiatric
<input type="checkbox"/> Headaches <input type="checkbox"/> Dizziness/vertigo <input type="checkbox"/> Numbness/tingling <input type="checkbox"/> Memory changes <input type="checkbox"/> Seizures <input type="checkbox"/> Weakness	<input type="checkbox"/> Depression <input type="checkbox"/> Anxiety <input type="checkbox"/> Sleep disturbances <input type="checkbox"/> Changes in mood <input type="checkbox"/> Suicidal thoughts
Hematologic/Lymphatic	Endocrine
<input type="checkbox"/> Easy bruising <input type="checkbox"/> Lymph node swelling <input type="checkbox"/> Bleeding tendencies <input type="checkbox"/> History of anemia	<input type="checkbox"/> Heat or cold intolerance <input type="checkbox"/> Excessive thirst or urination <input type="checkbox"/> Changes in weight <input type="checkbox"/> Thyroid changes

Additional notes