

PATIENT REVIEW OF SYSTEMS
 Please indicate what issues you are experiencing today.

Patient Name _____

GENERAL				MUSCULOSKELETAL		
				Arthritis	Y	N
Chills	Y	N		Back pain	Y	N
Fatigue	Y	N		Joint pain	Y	N
Fever	Y	N		Cramps	Y	N
Weight loss	Y	N		Swelling of joints	Y	N
Weight gain	Y	N		Muscle Pain	Y	N
Headache	Y	N		Stiffness of joints	Y	N
Decreased energy level	Y	N		Weakness of muscles	Y	N
SKIN				NEUROLOGICAL		
Persistent itching	Y	N		Dizziness	Y	N
Rash	Y	N		Balance issues	Y	N
Easy Bruising	Y	N		Lack of coordination	Y	N
Coldness to skin	Y	N		Numbness	Y	N
				Tingling in extremities	Y	N
				Tremors	Y	N
				Unsteadiness walking	Y	N
				Weakness		
RESPIRATORY						
Asthma	Y	N				
Cough	Y	N		PSYCHIATRIC		
Difficulty breathing	Y	N		Insomnia	Y	N
Shortness of breath	Y	N		Anxiety	Y	N
Bloody sputum	Y	N		Depression	Y	N
CARDIOVASCULAR				ENDOCRINE		
Angina	Y	N		Diabetes	Y	N
Chest pains	Y	N		Pituitary disease	Y	N
Arrhythmia	Y	N		Thyroid Disease	Y	N
Calf pain or cramps	Y	N				
High Blood Pressure	Y	N				
Swelling in legs	Y	N				
GASTROINTESTINAL				HEMATOLOGICAL		
Abdominal Pain	Y	N		Bleeding issues	Y	N
Constipation	Y	N		Blood Clots	Y	N
Diarrhea	Y	N		Itching with no rash	Y	N
Heartburn/ Reflux	Y	N				
Nausea or Vomiting	Y	N				
Black Stools	Y	N				
Diarrhea	Y	N				