Name: _____ Date of Appt: _____

DOB: _____

REVIEW OF SYSTEMS
Tae M. Shin, MD

1. CONSTITUTIONAL

Do you now have or have you recently had any of the following? ☐ No ☐ Yes If yes, mark all that apply.

- ☐ Chills
- ☐ Night Sweats
- ☐ Weight Loss
- ☐ Fever
- ☐ Weight Gain

2. CARDIOVASCULAR

Do you now have or have you recently had any of the following? ☐ No ☐ Yes If yes, mark all that apply.

- ☐ Chest Pain
- ☐ Edema
- ☐ Cold Extremity
- ☐ Palpitations

3. RESPIRATORY

Do you now have or have you recently had any of the following? ☐ No ☐ Yes If yes, mark all that apply.

- ☐ Cough
- ☐ Productive Cough
- ☐ Wheezing
- ☐ Coughing Up Blood
- ☐ Shortness of Breath

4. MUSCULOSKELETAL

Do you now have or have you recently had any of the following? ☐ No ☐ Yes If yes, mark all that apply.

- ☐ Joint Pain
- ☐ Muscle Pain/Tenderness

5. NEUROLOGIC

Do you now have or have you recently had any of the following? ☐ No ☐ Yes If yes, mark all that apply.

- ☐ Dizziness
- ☐ Headache
- ☐ Impaired Speech
- ☐ Seizure
- ☐ Fainting
- ☐ Impaired Balance
- ☐ Memory Loss

6. PSYCHIATRIC

Do you now have or have you recently had any of the following? ☐ No ☐ Yes If yes, mark all that apply.

- ☐ Depression
- ☐ Insomnia

7. HEMATOLOGIC/LYMPHATIC

Do you now have or have you recently had any of the following? ☐ No ☐ Yes If yes, mark all that apply.

- ☐ Easy Bruising
- ☐ Recurrent Infection
- ☐ Slow Wound Healing

8. ALLERGY/IMMUNOLOGY

Do you now have or have you recently had any of the following? ☐ No ☐ Yes If yes, mark all that apply.

- ☐ Cough
- ☐ Hoarseness
- ☐ Throat Pain
- ☐ Difficulty Swallowing
- ☐ Shortness of Breath

Name: _____ Date of Appt: _____

DOB: _____

REVIEW OF SYSTEMS (continued)
Tae M. Shin, MD

9. FALL RISK SCREENING

a. Have you experienced a fall in the past 6 months? ☐ No ☐ Yes

b. Do you have difficulty rising from a chair? ☐ No ☐ Yes

c. Are you currently taking any of the following medicines: narcotics, high blood pressure medicines, diuretics, blood thinners, or heart medications? ☐ No ☐ Yes

d. Do you experience dizziness when arising from bed or a chair? ☐ No ☐ Yes

e. Do you have an uncorrected vision problem (glaucoma, cataracts, blindness in 50% of vision field)? ☐ No ☐ Yes