Name: _____ Date of Appt: _____

DOB: _____

REVIEW OF SYSTEMS

1. CONSTITUTIONAL

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

- ☐ Anorexia
- ☐ Chills
- ☐ Difficulty Sleeping
- ☐ Fatigue
- ☐ Fever
- ☐ Malaise
- ☐ Night Sweats
- ☐ Weakness
- ☐ Weight Gain
- ☐ Weight Loss

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
- ☐ Chest Pressure
- ☐ Claudication
- ☐ Cold Extremity
- ☐ Cyanosis
- ☐ Diaphoresis
- ☐ Dyspnea
- ☐ Dyspnea On Exertion
- ☐ Edema
- ☐ Lightheadedness
- ☐ Orthopnea
- ☐ Palpitations
- ☐ Paroxysmal Nocturnal Dyspnea
- ☐ Reduced Exercise Tolerance
- ☐ Syncope
- ☐ Tachycardia

3. RESPIRATORY

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

- ☐ Apneic Episodes
- ☐ Chest Tightness
- ☐ Cough
- ☐ Dry Cough
- ☐ Dyspnea
- ☐ Hemoptysis
- ☐ Nocturnal Cough
- ☐ Pleuritic Chest Pain
- ☐ Productive Cough
- ☐ Stridor
- ☐ Wheezing

4. MUSCULOSKELETAL

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

- ☐ Ankle Pain
- ☐ Arm Pain
- ☐ Arthralgias
- ☐ Back Pain
- ☐ Deformity
- ☐ Elbow Pain
- ☐ Foot Pain
- ☐ Gait Abnormality
- ☐ Hand Pain
- ☐ Hip Pain
- ☐ Joint Crepitus
- ☐ Joint Erythema
- ☐ Joint Swelling
- ☐ Joint Warmth
- ☐ Knee Pain
- ☐ Leg Pain
- ☐ Muscle Cramps
- ☐ Muscle Swelling
- ☐ Muscle Weakness
- ☐ Myalgias
- ☐ Neck Pain
- ☐ Shoulder Pain
- ☐ Stiffness
- ☐ Wrist Pain

5. NEUROLOGIC

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

- ☐ Alteration Of Consciousness
- ☐ Ataxia
- ☐ Auras
- ☐ Confusion
- ☐ Dizziness
- ☐ Headache
- ☐ Impaired Balance
- ☐ Impaired Speech
- ☐ Memory Loss
- ☐ Numbness
- ☐ Paresthesias
- ☐ Paresis
- ☐ Photophobia
- ☐ Radicular Pain
- ☐ Scotomata
- ☐ Seizure
- ☐ Syncope
- ☐ Tics
- ☐ Tremor
- ☐ Weakness

Name: _____ Date of Appt: _____

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REVIEW OF SYSTEMS (continued)

6. PSYCHIATRIC

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

- ☐ Altered Body Image
- ☐ Anxiety
- ☐ Binge Drinking
- ☐ Depression
- ☐ Excess Energy
- ☐ Feeling Hopeless
- ☐ Feeling Worthless
- ☐ Inability To Concentrate
- ☐ Insomnia
- ☐ Loss Of Interests
- ☐ Substance Use Guilt
- ☐ Trying To Decrease Substance Use

7. HEMATOLOGIC/LYMPHATIC

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

- ☐ Bleeding Gums
- ☐ Easy Bruising
- ☐ Easy Bleeding
- ☐ Fatigue
- ☐ Lightheadedness
- ☐ Night Sweats
- ☐ Prolonged Bleeding
- ☐ Prolonged Infection
- ☐ 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
- ☐ Difficulty Swallowing
- ☐ Excessive Tearing
- ☐ Eye Itching
- ☐ Eye Redness
- ☐ Eyelid Swelling
- ☐ Facial Swelling
- ☐ Hives
- ☐ Hoarseness
- ☐ Nasal Congestion
- ☐ Nasal Drainage
- ☐ Nasal Itching
- ☐ Oropharyngeal Swelling
- ☐ Post Nasal Drip
- ☐ Shortness of Breath
- ☐ Sneezing
- ☐ Stridor
- ☐ Throat Itching
- ☐ Throat Pain
- ☐ Wheezing

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