Review of Systems: New Patient or Existing Patient (please circle one)

Name: _____ Today's Date: _____

Please mark an "X" next to the complaint or conditions or symptoms that apply to you.

Fatigue/ tired	
Fever	
Headaches	
Weight Loss	
Weight Gain	
Difficulty Seeing	
Dry Mouth	
Hearing problems	
Hoarse voice	
Sore Throat	
Swollen glands neck	
Trouble swallowing	
Chest Pain	
Palpitations	
Shortness of Breath	
Coughing	
Swollen Feet or ankles	
Use of Inhalers	
Wheezing	
Abdominal Pain	
Change in bowel habits	
Any blood in stool	
Nausea	
Vomiting	
Heartburn/ Reflux	
Decreased appetite	
Belching	
Diarrhea	
Constipation	

MALES ONLY:	
Blood in Urine	
Difficulty with Erection	
Low libido	
Foul odor to urine	
Getting up at night to urinate	
Slow stream	
Pain into testicles	
Swelling in groin	
Previous hernia?	
Concerns regarding STD?	
FEMALES ONLY:	
Irregular periods	
Painful periods	
Heavy periods	
Painful intercourse	
Abnormal vaginal discharge	
Concerns regarding STD's?	
Breast pain	
Breast lump	
Nipple discharge	
Low libido	
Menopause	
Burning with urination	
Increased Urinary Frequency	
Urinary Urgency	
Leakage of urine	

Back pain	
Joint pain	
Use of pain relievers for joint pain	
Muscle pain	
Swollen joints	
More joint pain in the morning	
Abnormal Bruising	
Thin skin	
Hair loss	
Nail problems	
Rash	
Mole that has changed	
Skin lesion that will not heal	
Anxiety	
Depression	
Trouble sleeping	
Trouble concentrating	
Mood swings	
New or increased stress	
Suicidal ideation	
Previous treatment for anxiety or depression	