Patient Name:________________________ **Date:** _____________________

Review of Systems

New Patients - Please √ the box for all symptoms you are experiencing on the following list
Return Visits - Please √ the box for any **NEW/CHANGED** symptoms experienced **since your last visit**

If there has been NO CHANGE √ here □

Symptom	Yes	Symptom	Yes
Weakness	□	Poor vision	□
Tiredness	□	Wears eye glasses	□
Loss of Appetite	□	Pain in eyes	□
Increased Appetite	□	Infection of the eyes	□
Weight Loss	□	Pain in the ears	□
Weight Gain	□	Ear drainage	□
Chills	□	Nosebleeds	□
Fever	□	Hoarseness	□
Night Sweats	□	Neck Pain	□
Rashes	□	Hair Loss	□
Skin Ulcers	□	Bleeding gums	□
Condition of Gums	□		
Goiter	□		
Heat intolerance	□	Frequent infection	□
Cold intolerance	□	Easy bruising	□
Increased Thirst	□	Swollen lymph nodes	□
Changes in Body Hair	□	Back pain	□
Chest Pain/tightness	□		
Shortness of Breath	□		
Heart racing	□	Calf/leg pain at rest	□
Irregular heart rate	□	Calf/Leg pain walking	□
Heart murmur	□	Swelling of legs/ankle	□
Breast lump/discharge	□	Purple coloring of the hands/feet	□
Pain with urination	□		
Burning with urination	□		
Frequent urination	□	Nausea	□
Loss of urine control	□	Vomiting	□
Large amounts of urine	□	Constipation	□
Urgency to urinate	□	Diarrhea	□
Difficulty swallowing	□	Black color in stool	□
Change in sexual drive	□	Blood in stool	□
Vaginal bleeding/discharge	□	Difficulty chewing	□
Discharge from penis	□		
Erection difficulty	□		

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Patient Signature

____________________________ **Date of Review**

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Provider signature