

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

Patient Signature

Date of Review

Provider signature