REVIEW OF SYSTEMS

PATIENT NAME: _____ **Date:**_____

General: ☐ NONE ☐ Excessive fatigue ☐ Weight gain ☐ Weight loss ☐ Night sweats ☐ Fever ☐ Loss of appetite

ENT: ☐ NONE ☐ Nose bleed ☐ Cold ☐ Cough ☐ Sore throat ☐ Ringing in ears

Cardiovascular: ☐ NONE ☐ Palpitations ☐ Leg Swelling ☐ Dizziness **Respiratory**: ☐ NONE ☐ Shortness of breath ☐ Chest pain

Stomach/Intestinal: ☐ NONE ☐ Difficulty swallowing ☐ Nausea ☐ Vomiting ☐ Abdominal pain ☐ Heartburn ☐ Constipation ☐ Diarrhea ☐ Blood in stool ☐ Stool incontinence ☐ Change in bowel habits

Kidney/Bladder: ☐ NONE ☐ Painful urination ☐ Frequent urination ☐ Incontinence ☐ Recurrent UTI ☐ Blood in urine ☐ Frequent bladder infection ☐ Difficulty urinating

Musculoskeletal: ☐ NONE ☐ Muscle weakness ☐ Joint stiffness ☐ Joint pain ☐ Joint Swelling ☐ Leg cramp

Neurology: ☐ NONE ☐ Headaches ☐ Memory loss ☐ Tingling numbness ☐ Seizures ☐ Gait abnormality ☐ Insomnia ☐ Dizziness

Hematology/Lymph: ☐ NONE ☐ Swollen glands ☐ Varicose veins ☐ Anemia ☐ Easy bruising

Allergy: ☐ NONE ☐ Runny nose ☐ Scratchy throat ☐ Itchy eyes ☐ Ear fullness ☐ Sinus congestion ☐ Stuffy nose

Pharmacy Name: _____ **Pharmacy Phone**: _____ **Pharmacy Address:** _____