# REVIEW OF SYSTEMS

**GENERAL:**
- **Weight Loss?**
  - [ ] YES
  - [ ] NO
  - How much?
- **Decrease in energy?**
  - [ ] YES
  - [ ] NO
- **Decrease in appetite?**
  - [ ] YES
  - [ ] NO
- **Night sweats?**
  - [ ] YES
  - [ ] NO
- **Fever?**
  - [ ] YES
  - [ ] NO
  - If so, how high?

**Head, Eyes, Ears, Nose, Throat:**
- Sinus infection/pain?
  - [ ] YES
  - [ ] NO
- **Ear pain?**
  - [ ] YES
  - [ ] NO
- **Change in hearing?**
  - [ ] YES
  - [ ] NO
- **Eye pain?**
  - [ ] YES
  - [ ] NO
- **Change in vision?**
  - [ ] YES
  - [ ] NO
- **Nasal discharge?**
  - [ ] YES
  - [ ] NO
- **Throat pain?**
  - [ ] YES
  - [ ] NO

**CARDIAC:**
- **Chest pain?**
  - [ ] YES
  - [ ] NO
- **Shortness of breath?**
  - [ ] YES
  - [ ] NO
- **Fatigue?**
  - [ ] YES
  - [ ] NO
- **Episodes of shortness of breath at night?**
  - [ ] YES
  - [ ] NO
- **Decrease in ability to exert oneself?**
  - [ ] YES
  - [ ] NO

**RESPIRATORY:**
- **Blood in sputum?**
  - [ ] YES
  - [ ] NO
- **Cough or change in cough?**
  - [ ] YES
  - [ ] NO
- **Shortness of breath when lying down?**
  - [ ] YES
  - [ ] NO
- **Mucous production with cough?**
  - [ ] YES
  - [ ] NO

**GASTROINTESTINAL:**
- **Difficulty swallowing food?**
  - [ ] YES
  - [ ] NO
- **Pain with swallowing food?**
  - [ ] YES
  - [ ] NO
- **Indigestion?**
  - [ ] YES
  - [ ] NO
- **Nausea?**
  - [ ] YES
  - [ ] NO
- **Vomiting?**
  - [ ] YES
  - [ ] NO
- **Diarrhea?**
  - [ ] YES
  - [ ] NO
- **Abdominal bloating?**
  - [ ] YES
  - [ ] NO
- **Black stools?**
  - [ ] YES
  - [ ] NO
- **Blood from the rectum?**
  - [ ] YES
  - [ ] NO

**MUSCULOSKELETAL:**
- **Arthritis?**
  - [ ] YES
  - [ ] NO
- **Back pain?**
  - [ ] YES
  - [ ] NO
- **New back pain?**
  - [ ] YES
  - [ ] NO
- **Bone pain?**
  - [ ] YES
  - [ ] NO
- **Muscle soreness?**
  - [ ] YES
  - [ ] NO
- **Recent trauma or fractures?**
  - [ ] YES
  - [ ] NO

**SKIN:**
- **Infections?**
  - [ ] YES
  - [ ] NO
- **Ulcers?**
  - [ ] YES
  - [ ] NO
- **Rashes?**
  - [ ] YES
  - [ ] NO

**NEUROLOGICAL:**
- **Headaches?**
  - [ ] YES
  - [ ] NO
- **Troublesome or frequent headaches?**
  - [ ] YES
  - [ ] NO
- **Recent change in vision?**
  - [ ] YES
  - [ ] NO
- **Recent change in hearing?**
  - [ ] YES
  - [ ] NO
- **Change in ability to feel things?**
  - [ ] YES
  - [ ] NO
- **Painful sensations?**
  - [ ] YES
  - [ ] NO
- **Decrease in muscle strength?**
  - [ ] YES
  - [ ] NO
- **Decrease in ability to ambulate?**
  - [ ] YES
  - [ ] NO

**HEMATOLOGIC:**
- **Nosebleeds, rectal bleeding, or bleeding at other sites? (please specify)**
  - [ ] YES
  - [ ] NO

**EXTREMITIES:**
- **Redness of a limb?**
  - [ ] YES
  - [ ] NO
- **Swelling of a limb?**
  - [ ] YES
  - [ ] NO
- **Discoloration of a limb?**
  - [ ] YES
  - [ ] NO

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Form: 879103 Rev.1 02/17 Page 1 of 1