Name:_____ **Date:**_____

Review Of Systems

Constitutional:

Have you experienced:

Unexplained weight loss	Yes	No
Night sweats	Yes	No
Fevers	Yes	No
Chills	Yes	No

In the past Week, have you experienced:

HEENT:

Nose bleeds	Yes	No
Sinus pressure	Yes	No
Eye pain or eye pain with movement	Yes	No
Sensitivity to light	Yes	No
Blurry vision	Yes	No
Decreased sense of smell	Yes	No
Sore throat	Yes	No
Trouble swallowing	Yes	No
Post Nasal Drip	Yes	No
Headache	Yes	No
Snoring	Yes	No

Respiratory

Shortness of breath	Yes	No
Coughing up blood	Yes	No
Chest tightness	Yes	No
Chest Pressure	Yes	No

Cardiac

Chest Pain	Yes	No
Must sleep with more than one pillow	Yes	No
Fainting for unknown reasons	Yes	No
Fainting with activity or dizziness with exercise	Yes	No

GI

Flushing with diarrhea	Yes	No
Blood with bowl movements	Yes	No

Derm

Hives	Yes	No
Unusual rash	Yes	No
Itch	Yes	No

Heme

Easy bruising	Yes	No

Endo

Fatigue	Yes	No
Hair falling out more than usual	Yes	No
Always cold when others are hot or warm	Yes	No
Always hot when others are cold	Yes	No

Extremity

Joint swelling	Yes	No
Joint Pain	Yes	No

Lymph

Any enlarged nodules or bumps in neck, under the arm groin or other location?	Yes	No

Immune

Swelling of tongue, lips, hands, stomach or other	Yes	No