

Cool Springs Family Medicine

Review of Systems

Patient Name: _____

Constitutional

weight loss Yes No
 weight gain Yes No
 loss of appetite Yes No
 fever Yes No
 fatigue Yes No

ENT/Respiratory

congestion Yes No
 cough Yes No
 nose bleeds Yes No
 hearing loss Yes No
 change in voice Yes No
 sore throat Yes No
 ringing in ears Yes No
 sinus pain Yes No
 shortness of breath Yes No
 wheezing Yes No

Cardiology

decreased exercise tolerance Yes No
 murmurs Yes No
 palpitations Yes No
 high blood pressure Yes No
 chest pain Yes No
 swelling Yes No
 varicose veins Yes No
 poor circulation Yes No

Gastroenterology

blood in stool Yes No
 diarrhea Yes No
 vomiting Yes No
 constipation Yes No
 nausea Yes No
 difficulty swallowing Yes No
 abdominal pain Yes No
 change in bowel habits Yes No
 heartburn Yes No

Musculoskeletal

joint stiffness Yes No
 joint pain Yes No
 joint swelling Yes No
 sciatica Yes No
 fracture Yes No
 wrist pain/tingling Yes No
 knee pain Yes No
 back pain Yes No

Dermatology

rash Yes No
 change in size/shape of moles Yes No
 lumps Yes No
 dry or sensitive skin Yes No
 acne Yes No
 ulcers Yes No

Genitourinary Male

difficulty urinating Yes No
 frequent nighttime urination Yes No
 hernia Yes No
 undescended testicle Yes No
 blood in urine Yes No
 penile discharge Yes No
 genital sore/ulcer Yes No

Genitourinary Female

irregular periods Yes No
 painful periods Yes No
 heavy periods Yes No
 pelvic pain Yes No
 painful urination Yes No
 increased urinary frequency Yes No
 blood in urine Yes No
 vaginal discharge Yes No
 genital sore/ulcer Yes No

Ophthalmology

diminished vision Yes No
 eye irritation or discharge Yes No
 blurring of vision Yes No
 spots in vision Yes No
 sudden vision loss Yes No

Hematology/Lymphatic

easy bleeding/bruising Yes No
 swollen lymph nodes Yes No

Endocrinology

excessive sweating Yes No
 excessive thirst Yes No
 excessive urination Yes No
 cold intolerance Yes No
 heat intolerance/hot flashes Yes No

Psychology

depression Yes No
 anxiety/panic Yes No
 sleep disturbances/insomnia Yes No
 poor concentration Yes No
 irritability Yes No
 mood swings Yes No
 suicidal thoughts Yes No
 mental, physical or sexual abuse Yes No
 excessive energy Yes No
 trouble staying on task Yes No

Neurology

weakness Yes No
 numbness/tingling Yes No
 headache Yes No
 dizziness Yes No
 balance problem Yes No
 memory loss Yes No