Cool Springs Family Medicine
Review of Systems

Patient Name:____ *Please give to the nurse when finished.

Constitutional

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

ENT/Respiratory

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

Cardiology

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

Gastroenterology

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

Musculoskeletal

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

Dermatology

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

Genitourinary Male

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

Genitourinary Female

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

Ophthalmology

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

Hematology/Lymphatic

easy bleeding/bruising	O Yes O No
swollen lymph nodes	O Yes O No

Endocrinology

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

Psychology

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

Neurology

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