

Review Of Systems Questionnaire

Have you been feeling any of these symptoms today?

Patient Name _____ DOB _____

Today's Date:

Constitutional	Yes	No	*	Chest	Yes	No
Feeling tired or poorly			*	Difficulty swallowing		
Fever (as symptom)			*	A cough		
Chills (as symptom)			*	Shortness of breath		
Recent weight loss(lbs _____)			*	Palpitations		
Recent weight gain(lbs _____)			*	Chest pain or discomfort		

Ear, Nose, Throat	Yes	No	*	Hemo/Endocrine	Yes	No
Nasal congestion			*	An easy bruising tendency		
Post-nasal drip			*	Excessive sweating		
Sore throat			*	Sweating heavily at night		
Earache (right)			*	Excessive thirst		
Earache (left)			*	Temperature intolerance		

Urinary	Yes	No	*	Neuro/Eyes	Yes	No
Pain during urination			*	Headache		
Increased urination			*	Dizziness		
Blood in urine			*	Ringing in ears		
Urinating more than 1 x night			*	Numbness		
			*	Decrease in strength		
			*	Red Eyes		
			*	Sleep disturbances		
			*	Depression		
			*	Anxiety		

GI	Yes	No	*	Gynecological (women)	Yes	No
Decreased appetite			*	Unexplained vaginal bleeding		
Abdominal Pain			*	Vaginal discharge		
Nausea			*	Vaginal pain		
Vomiting			*	Vaginal itching or burning		
Diarrhea			*			
Constipation			*			
Heartburn			*			
Blood in stool			*			

Skin/Musculoskeletal	Yes	No
Skin rash		
Neck pain		
Back pain		
Joint pain		