

# Comprehensive Review of Systems

(Please circle Yes or No)

Name: \_\_\_\_\_

## Constitutional

Weight change Yes or No  
Loss of appetite Yes or No  
Fever Yes or No  
Weakness Yes or No  
Night sweats Yes or No  
Breast feeding (if applicable) Yes or No

## Dermatology

Suspicious lesions Yes or No  
Suspicious moles Yes or No  
Rash Yes or No  
Itching Yes or No  
Dry or sensitive skin Yes or No  
Photosensitivity Yes or No  
Hives Yes or No  
Hair loss Yes or No  
Lumps Yes or No  
Jaundice Yes or No

## ENT

Nose bleeds Yes or No  
Change in voice Yes or No  
Sore throat Yes or No  
Difficulty swallowing Yes or No

## Respiratory

Shortness of breath Yes or No  
Chest tightness Yes or No  
Cough Yes or No  
Wheezing Yes or No  
Congestion Yes or No

## Gastroenterology

Blood in stool Yes or No  
Diarrhea Yes or No  
Vomiting Yes or No  
Constipation Yes or No  
Nausea Yes or No  
Abdominal pain Yes or No  
Change in bowel habits Yes or No

## Psychology

Depression Yes or No  
High stress Yes or No  
Mood swings Yes or No  
Suicidal ideation Yes or No  
Obsessive-compulsive tendencies Yes or No

## Neurology

Headache Yes or No  
Tingling numbness Yes or No  
Seizures Yes or No  
Dizziness Yes or No  
Focal weakness Yes or No

## Genitourinary Female

Premenstrual Syndrome Yes or No  
Infertility Yes or No  
Dysmenorrheal Yes or No  
Frequent yeast infections Yes or No  
Vaginal itching Yes or No  
Intermenstrual bleeding Yes or No  
Pelvic pain Yes or No  
Sexual activity Yes or No  
Irregular periods Yes or No  
Abnormal vaginal discharge Yes or No

## Ophthalmology

Eye irritation Yes or No  
Drainage from eyes Yes or No  
Blurring of Vision Yes or No

## Hematology

Easy bruising Yes or No  
Swollen glands Yes or No  
Fatigue Yes or No

## Endocrinology

Excessive thirst Yes or No  
Excessive sweating Yes or No  
Excessive urination Yes or No  
Cold intolerance Yes or No  
Heat intolerance Yes or No

## Allergy

Runny nose Yes or No  
Scratchy throat Yes or No  
Itchy eyes Yes or No  
Sneezing Yes or No  
Ear fullness Yes or No  
Stuffy nose Yes or No  
Cough Yes or No

## Musculoskeletal

Joint stiffness Yes or No  
Leg cramps Yes or No  
Joint pain Yes or No  
Joint swelling Yes or No  
Back pain Yes or No  
Neck pain Yes or No  
Muscle aches Yes or No

## Urology

Difficulty urinating Yes or No  
Blood in urine Yes or No  
urinary urgency Yes or No  
Frequent urination Yes or No  
Urinary incontinence Yes or No

## Cardiology

Palpitations Yes or No  
Chest pains Yes or No  
High blood Pressure Yes or No