NAME________________________________

Review of Systems

Do you currently have problems in any of the following areas? Circle Yes or No.

Cardiac

Y N Chest Pain

Y N Palpitations

Y N Excessive Sweating

Y N Fainting

Y N Difficulty Breathing when Lying Flat

Y N Difficulty Breathing at Night

Vascular

Y N Pain in calves when walking

Y N Swelling in Extremities

Constitutional

Y N Weight Gain

Y N Weight Loss

Y N Fever

HEENT

Y N Vision Changes

Y N Hearing Loss

Pulmonary

Y N Snoring

Y N Coughing Up Blood

Y N Difficulty Breathing

Gastrointestinal

Y N Nausea

Y N Reflux

Y N Bleeding

Genitourinary

Y N Blood in Urine

Y N Frequent Urination at Night

Neurological

Y N Dizziness

Y N Memory Loss

Y N Seizures

Psychiatric

Y N Depression

Y N Hallucinations

Hematologic

Y N Acute Anemia

Y N Low Platelet Count

Musculoskeletal

Y N Joint Pain

Y N Muscle Pain