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Review of Systems Questionnaire

Patient name: _____ Today's date: _____

Date of birth: _____ Age: _____

Are you currently experiencing or have recently experienced any of the following (please check all that apply):

1. General:
   - ☐ Weight gain or loss
   - ☐ Fatigue
   - ☐ Fever/chills
   - ☐ Sleep disturbance
2. Eyes:
   - ☐ Blurred Vision
   - ☐ Decreased vision
   - ☐ Eye pain or itching
3. ENT (Ears/Nose/Throat):
   - ☐ Nasal congestion/itching
   - ☐ Nosebleeds
   - ☐ Sinus pain/pressure
   - ☐ Difficulty swallowing
   - ☐ Mouth sores or thrush
4. Respiratory:
   - ☐ Cough
   - ☐ Wheeze
   - ☐ Shortness of breath
   - ☐ Coughing up blood
   - ☐ Snoring
5. Allergy
   - ☐ Nasal congestion
   - ☐ Nasal drainage
   - ☐ Itchy skin
   - ☐ Itchy/red eyes
   - ☐ Itchy nose
   - ☐ Rash
6. Cardiovascular:
   - ☐ Chest pain or tightness
   - ☐ Palpitations
   - ☐ Shortness of breath with activity
   - ☐ Difficulty sleeping lying down
7. Gastrointestinal:
   - ☐ Abdominal pain
   - ☐ Nausea or vomiting
   - ☐ Diarrhea
   - ☐ Constipation
   - ☐ Heartburn or acid reflux
8. Genital/Urinary:
   - ☐ Infections
   - ☐ Stones
9. Endocrine:
   - ☐ Increased appetite or thirst
   - ☐ Increased urination
   - ☐ Always hot or cold
   - ☐ Hair loss
10. Musculoskeletal:
    - ☐ Weakness
    - ☐ Joint pain or swelling
    - ☐ Back Pain
11. Skin:
    - ☐ Rash
    - ☐ Itching
    - ☐ Dryness
    - ☐ Hair/nail changes
12. Neurologic:
    - ☐ Headaches
    - ☐ Dizziness/Faintness
    - ☐ Numbness or tingling
13. Hematologic:
    - ☐ Easy bruising or bleeding
    - ☐ Blood in urine or stool
14. Psychiatric:
    - ☐ Anxiety
    - ☐ Depression
    - ☐ Memory loss