

Internal Medicine Clinic - Review of Systems

Name: _____

DOB: _____

Today's date: _____

CONSTITUTIONAL

Fever	Yes	No
Fatigue	Yes	No
Weight Loss	Yes	No
Chills	Yes	No
Sweats	Yes	No
Additional		

EYES

Altered Vision	Yes	No
Eye Pain	Yes	No
Eye Irritation	Yes	No
Additional		

EARS,NOSE,THOAT

Dizziness	Yes	No
Earaches	Yes	No
Nose Bleeds	Yes	No
Hearing Loss	Yes	No
Hoarseness	Yes	No
Nasal Discharge	Yes	No
Oral Lesions	Yes	No
Oral Pain	Yes	No
Ringing/Ears	Yes	No
Additional		

RESPIRATORY

Shortness of Breath	Yes	No
Chronic Cough	Yes	No
Coughing Blood	Yes	No
Mucos,Phlegm	Yes	No
Wheezing	Yes	No
Additional		

CARDIOVASCULAR

Chest Pain	Yes	No
Excessive Sweating	Yes	No
Edema	Yes	No
Palpitations	Yes	No
Night Shortness of Breath	Yes	No
Additional		

GASTROINTESTIAL

Abdominal Pain	Yes	No
Bloody Stools	Yes	No
Black Stools	Yes	No
Changes in Stool	Yes	No
Diarrhea	Yes	No
Heartburn	Yes	No
Nausea/Vomiting	Yes	No
Additional		

URINARY

Night Time Urination	Yes	No
Excessive Urinary Frequency	Yes	No
Sexual Dysfunction	Yes	No
Painful Urination	Yes	No
Urinary Hesitation	Yes	No
Impotence	Yes	No
Incontinence	Yes	No
Menstral Irregularity	Yes	No

URINARY (continued)

Penile or Genital Ulcers	Yes	No
Urgency	Yes	No
Additional		

MUSCULOSKELETAL

Joint Pain	Yes	No
Joint Stiffness	Yes	No
Muscle Aches	Yes	No
Back Pain	Yes	No
Serious Bone/Joint Injury	Yes	No
Joint Swelling	Yes	No
Additional		

SKIN

Abnormal Pigmentation	Yes	No
Lesions	Yes	No
Additional		

NEUROLOGICAL

Headache	Yes	No
Numbness	Yes	No
Weakness	Yes	No
Shakiness	Yes	No
Confusion	Yes	No
Memory Loss	Yes	No
Abnormal Skin Sensation	Yes	No
Tremors	Yes	No
Additional		

ENDOCRINE

Heat/Cold Intolerance	Yes	No
Extreme Thirst	Yes	No
Excessive Urination	Yes	No

HEMATOLOGY

Anemia	Yes	No
Excessive Bruising	Yes	No
Itching	Yes	No
Leg Ulcers	Yes	No
Rash	Yes	No
Enlarged Lymph Nodes	Yes	No
Additional		

IMMUN/ALLERGY

Hives	Yes	No
Seasonal Allergies	Yes	No
Additional		

MENTAL HEALTH

Anxiety	Yes	No
Depression	Yes	No
Agitation	Yes	No
Disorientation	Yes	No
Hallucinations	Yes	No
Additional		

IMMUNIZATIONS

	Date of Last
Tetanus	<input type="text"/>
Pneumovax	<input type="text"/>
Influenza	<input type="text"/>
Zostavax/Shingles	<input type="text"/>