

Patient name: _____ Date: _____

REVIEW OF SYSTEMS

Do you currently have any problems in the following areas? If yes, provide information.

	YES	NO	Explanation of Problem
Constitutional Symptoms	<input type="checkbox"/>	<input type="checkbox"/>	_____
Fever	<input type="checkbox"/>	<input type="checkbox"/>	_____
Weight Loss	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ears, nose, mouth, throat	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sinus congestion	<input type="checkbox"/>	<input type="checkbox"/>	_____
Runny nose	<input type="checkbox"/>	<input type="checkbox"/>	_____
Post nasal drip	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chronic cough	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dry throat/mouth	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cardiovascular (heart/blood vessels)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Respiratory (lungs/breathing)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chronic bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Gastrointestinal (stomach/intestines)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Genitourinary (genitals/kidney/bladder)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Musculoskeletal	<input type="checkbox"/>	<input type="checkbox"/>	_____
Muscle	<input type="checkbox"/>	<input type="checkbox"/>	_____
Joint	<input type="checkbox"/>	<input type="checkbox"/>	_____
Integumentary (skin and/or breast)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Neurological	<input type="checkbox"/>	<input type="checkbox"/>	_____
Psychiatric	<input type="checkbox"/>	<input type="checkbox"/>	_____
Disorders of the glands/thyroid	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hematologic/Lymphatic	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blood	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lymph nodes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Swelling	<input type="checkbox"/>	<input type="checkbox"/>	_____
Allergic/Immunologic	<input type="checkbox"/>	<input type="checkbox"/>	_____
Head allergy symptoms	<input type="checkbox"/>	<input type="checkbox"/>	_____
Seasonal allergies	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hay fever symptoms	<input type="checkbox"/>	<input type="checkbox"/>	_____
