REVIEW OF SYSTEMS CHECKLIST

Please place a check in the box if you have any of the following:

General

- ☐ Weight loss and gain
- ☐ Fever or chills
- ☐ Trouble sleeping
- ☐ Fatigue
- ☐ Weakness

Skin

- ☐ Rashes
- ☐ Itching
- ☐ Color changes
- ☐ Lumps
- ☐ Dryness
- ☐ Hair and nail changes

Head

- ☐ Headache
- ☐ Head injury

Ears

- ☐ Decreased hearing
- ☐ Earache
- ☐ Ringing in ears (tinnitus)
- ☐ Drainage

Eyes

- ☐ Vision
- ☐ Cataracts
- ☐ Blurry or double vision
- ☐ Glasses or contacts
- ☐ Flashing lights
- ☐ Last eye exam
- ☐ Pain
- ☐ Specks
- ☐ Redness
- ☐ Glaucoma

Nose

- ☐ Stuffiness
- ☐ Itching
- ☐ Nosebleeds
- ☐ Discharge
- ☐ Hay fever
- ☐ Sinus pain

PATIENT NAME: _____ **DOB:** _____ **DATE:** _____

Throat

- ☐ Teeth
- ☐ Gums
- ☐ Bleeding
- ☐ Dentures
- ☐ Sore tongue
- ☐ Dry mouth
- ☐ Sore throat
- ☐ Hoarseness
- ☐ Thrush
- ☐ Non-healing sores
- ☐ Last dental exam

Neck

- ☐ Lumps
- ☐ Swollen glands
- ☐ Pain
- ☐ Stiffness

Breasts

- ☐ Lumps
- ☐ Pain
- ☐ Discharge
- ☐ Self-exams
- ☐ Breast-feeding
- ☐ Prior biopsy/surgery

Respiratory

- ☐ Cough (dry or wet, productive)
- ☐ Sputum (color and amount)
- ☐ Painful breathing
- ☐ Shortness of breath
- ☐ Coughing up blood (hemoptysis)
- ☐ Wheezing

Neuro

- ☐ Awake, alert/ oriented
- ☐ Gait (normal or abnormal)
- ☐ Sensory intact
- ☐ CN II- XII intact
- ☐ Other _____
- ☐ Other _____

PATIENT NAME: _____ **DOB:** _____ **DATE:** _____

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