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

Neck

Lumps | Pain
Swollen glands | Stiffness

Breasts

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

Respiratory

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

Neuro

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

PATIENT NAME: _____ DOB: _____ DATE: _____

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