

**Review of Systems**  
Please respond **Y** or **N** to each item

Patient Name \_\_\_\_\_  
Date \_\_\_\_\_

Y N

**General Health**

- Appetite loss
- Fever
- High Blood Pressure
- Recent weight loss
- Unusual weakness or fatigue

**HENT**

- Hearing loss
- Nosebleeds or runny nose
- Sore throat or hoarseness
- Throat swelling

**Cardiovascular**

- Leg swelling
- Palpitations
- Shortness of breath when lying down
- Slow or rapid heart beat

**Gastrointestinal**

- Blood in stool or black tarry stool
- Constipation or diarrhea
- Nausea or vomiting
- Pain or bloating

Y N

**Genitourinary**

- Abnormal pap smears
- Bleeding between periods or after menopause  
or irregular periods
- Heavy vaginal bleeding or painful bleeding
- Painful intercourse
- Painful urination or urinary frequency
- Sexually transmitted diseases
- Vaginal discharge

**Breast/Skin**

- Abrasions or lacerations
- Do you do monthly self breast exams?
- Lumps, masses or discharge
- Rash, bruising, swelling

**Hematology**

- Anemia or blood transfusions
- Easy bruising or abnormal bleeding
- Swollen lymph nodes

**Endocrine**

- Change in hair
- Excessive thirst
- Fatigue or weakness

**Muscles or Joints**

- Pain or stiffness
- Redness or heat or inflammation