REVIEW OF SYSTEMS

Name_____Date of Birth_____

Please circle all of the following symptoms/problems which have **changed or are new** since your last visit:

Fever	Vaginal discharge	Unusual fatigue
Pain w intercourse	Night sweats	Abnormal periods
Significant change in weight	Spotting / Bleeding	Unusual or severe headaches
Vision disturbance	Dizziness	Hearing difficulties
Abn weak or numb limbs	Ringing in ears	Ear pain
Feel off balance	Nasal congestion	Sleep difficulties
Nasal discharge	Anxious	Itchy/watery eyes
Depressed	Sore throat	Irritable
Frequent Cough	Rash	Shortness of breath
Changing moles	Wheezing	Problem w hair or nails
Muscle pain	Chest pain	Swelling in joints
Palpitations	Back problems	Fainting
Bruising	Cramps in legs	Unusual bleeding
Swelling in feet/legs	Food allergies	Nausea/vomiting
Constipation	Diarrhea	Frequent infections
Abdominal pain	Black/bloody stools	Burning w/ urination
Urinary frequency	Leakage of urine	Urgency to urinate
Slow/weak stream	Blood in urine	Urethral discharge

Other problems you would like to discuss with doctor_____

_____

We know this form is an inconvenience to you, but we ask that this be completed each and every time that you visit. We appreciate your understanding and help so that we may understand and help bring you the best healthcare possible.