## Review of Systems

Do you have any allergies other than to medications (such as to latex, shellfish, etc)?

☐ Yes ☐ No  If YES, Describe

### Do you have any of the following?

**General:**

| | | |
|---|---|---|
| Recent Weight Loss of More than 10 pounds? | ☐ Yes | ☐ No |
| Recent Weight Gain of More than 10 pounds? | ☐ Yes | ☐ No |
| Fever: | ☐ Yes | ☐ No |
| Chills: | ☐ Yes | ☐ No |
| Night Sweats: | ☐ Yes | ☐ No |

Have you seen your primary care physician in the past year? ☐ Yes ☐ No

**Cardiac:**

| | | |
|---|---|---|
| Chest pain: | ☐ Yes | ☐ No |
| Shortness of Breath | ☐ Yes | ☐ No |

**Respiratory:**

| | | |
|---|---|---|
| Wheezing | ☐ Yes | ☐ No |
| Pneumonia | ☐ Yes | ☐ No |
| Chronic Cough | ☐ Yes | ☐ No |

**Gastrointestinal:**

| | | |
|---|---|---|
| Abdominal Pain | ☐ Yes | ☐ No |
| Nausea | ☐ Yes | ☐ No |
| Vomiting | ☐ Yes | ☐ No |
| Diarrhea | ☐ Yes | ☐ No |
| Liver Problems | ☐ Yes | ☐ No |

**Skin:**

| | | |
|---|---|---|
| Open Sores | ☐ Yes | ☐ No |
| New Moles | ☐ Yes | ☐ No |
| Poor Healing | ☐ Yes | ☐ No |
| Skin Infection | ☐ Yes | ☐ No |

**Hematologic/Oncologic**

| | | |
|---|---|---|
| Easy Bleeding | ☐ Yes | ☐ No |
| Blood Thinning Medications | ☐ Yes | ☐ No |
| Blood Transfusion | ☐ Yes | ☐ No |
| Organ Transplant | ☐ Yes | ☐ No |

**Bones/Joints**

| | | |
|---|---|---|
| Shoulder Pain | ☐ Yes | ☐ No |
| Wrist/Hand Pain | ☐ Yes | ☐ No |
| Hip Pain | ☐ Yes | ☐ No |
| Knee Pain | ☐ Yes | ☐ No |
| Lupus | ☐ Yes | ☐ No |
| Muscle Weakness | ☐ Yes | ☐ No |
| Fibromyalgia | ☐ Yes | ☐ No |

**Genito-urinary**

| | | |
|---|---|---|
| Abnormal kidney function | ☐ Yes | ☐ No |
| Pain with urination | ☐ Yes | ☐ No |
| Frequent urinary infection | ☐ Yes | ☐ No |

**Mental Health:**

| | | |
|---|---|---|
| Sleep Disturbances | ☐ Yes | ☐ No |
| Feeling of Hopelessness | ☐ Yes | ☐ No |

**Nervous System**

| | | |
|---|---|---|
| Headaches | ☐ Yes | ☐ No |
| Tremors | ☐ Yes | ☐ No |
| Poor Speech | ☐ Yes | ☐ No |
| Changes in Vision | ☐ Yes | ☐ No |

**Endocrine**

| | | |
|---|---|---|
| Thyroid Problems | ☐ Yes | ☐ No |