Patient Name:_____

Date of Birth:_____

Panhandle Health District

Review of Systems

Are you currently experiencing any of the following. Please check mark those items that apply.

CONSTITUTIONAL

- ☐ Chills
- ☐ Fatigue
- ☐ Fever
- ☐ Body weakness/discomfort
- ☐ Night sweats
- ☐ Weight gain
- ☐ Weight loss
- ☐ Other:
- NONE

HEAD, EYES, EARS, NOSE, THROAT

- ☐ Ear drainage
- ☐ Ear pain
- ☐ Eye discharge
- ☐ Eye pain
- ☐ Hearing loss
- ☐ Nasal drainage
- ☐ Sinus pressure
- ☐ Sore throat
- ☐ Visual changes
- ☐ Other:
- ☐ **NONE**

RESPIRATORY

- ☐ Chronic cough
- ☐ Cough
- ☐ Known TB exposure
- ☐ Shortness of breath
- ☐ Wheezing
- ☐ Other:
- ☐ **NONE**

CARDIOVASCULAR

- ☐ Chest pain
- ☐ Pain in legs when walking
- ☐ Swelling
- ☐ Palpitations
- ☐ Other:
- ☐ **NONE**

GASTROINTESTINAL

- ☐ Abdominal pain
- ☐ Blood in stools
- ☐ Change in stools
- ☐ Constipation
- ☐ Diarrhea
- ☐ Heartburn
- ☐ Loss of appetite
- ☐ Nausea
- ☐ Vomiting
- ☐ Other:
- ☐ **NONE**

GENITOURINARY

- ☐ Painful/Burning Urination
- ☐ Blood in urine
- ☐ Excessive Urination
- ☐ Urinary Frequency
- ☐ Inability to Hold Urine (incontinence)
- ☐ Urinary Retention
- ☐ Other:
- ☐ **NONE**

REPRODUCTIVE - FEMALE

- ☐ Abnormal pap
- ☐ Painful periods
- ☐ Painful sex
- ☐ Hot flashes
- ☐ Irregular periods
- ☐ Vaginal discharge
- ☐ Birth Control **Y** **N**
  Method:_____
- ☐ Sexually Transmitted Disease(s)
  _____
- ☐ Other:
- ☐ NONE

REPRODUCTIVE - MALE

- ☐ Erection Problems
- ☐ Discharge from Penis
- ☐ Sexual Problems
- ☐ Sexually Transmitted Disease(s)
  _____
- ☐ Sores/Bumps in Genital Area
- ☐ Other:
- ☐ **NONE**

INTEGUMENTARY

- ☐ Breast discharge
- ☐ Breast lump
- ☐ Brittle hair
- ☐ Brittle nails
- ☐ Hair loss
- ☐ Excessive hair growth
- ☐ Hives
- ☐ Itching
- ☐ Mole changes
- ☐ Rash
- ☐ Skin changes
- ☐ Other:
- ☐ **NONE**

NEUROLOGICAL

- ☐ Dizziness
- ☐ Extremity numbness
- ☐ Extremity weakness
- ☐ Gait disturbance
- ☐ Headache
- ☐ Memory loss
- ☐ Seizures
- ☐ Tremors
- ☐ Other:
- ☐ **NONE**

PSYCHIATRIC

- ☐ Anxiety
- ☐ Depression
- ☐ Insomnia
- ☐ Other:
- ☐ **NONE**

METABOLIC / ENDOCRINE

- ☐ Cold intolerance
- ☐ Heat intolerance
- ☐ Excessive thirst
- ☐ Excessive hunger
- ☐ Other:
- ☐ **NONE**

MUSCULOSKELETAL

- ☐ Back pain
- ☐ Joint pain
- ☐ Joint swelling
- ☐ Muscle weakness
- ☐ Neck pain
- ☐ Other:
- ☐ **NONE**

HEMATOLOGIC / LYMPHATIC

- ☐ Easy bleeding
- ☐ Easy bruising
- ☐ Enlarged lymph nodes
- ☐ Other:
- ☐ **NONE**

IMMUNOLOGIC

- ☐ Contact allergy
- ☐ Environmental allergies
- ☐ Food allergies
- ☐ Seasonal allergies
- ☐ Other:
- ☐ **NONE**