Patient Name _____ Date of Birth _____

Review of Systems: Please circle and explain any symptoms you are having on a consistent basis

- **General:** Fever, Loss in height, weight gain, unexplained weight loss
  If yes, please explain _____
- **Skin:** Acne, change in mole, excess hair growth, excess hair loss, new lesions, rash, skin discoloration
  If yes, please explain _____
- **HEENT:** Contacts, hearing problems, change in vision, cold sores, nose bleeds, enlarged lymph nodes, dry mouth
  If yes, please explain _____
- **Respiratory:** Chronic cough, shortness of breath, coughing up blood, wheezing
  If yes, please explain _____
- **Breast:** Breast pain, dimpling, nipple discharge, lump, skin changes
  If yes, please explain _____
- **Cardiovascular:** Chest pain, chest pressure, difficulty breathing on exertion, rapid heartbeat, varicose veins, calf pain, swelling of the legs, palpitations
  If yes, please explain _____
- **Genitourinary:** Menstrual bleeding problems, menopausal symptoms, vaginal/vulvar problems, premenstrual problems, sexual problems, urinary urgency, frequency or problems
  If yes, please explain _____
- **Musculoskeletal:** Joint pain, joint swelling, muscle pain, muscle weakness
  If yes, please explain _____
- **Neurological:** Frequent headaches, dizziness, fainting, numbness or tingling, weakness, sleep problems
  If yes, please explain _____
- **Psychiatric:** Mood changes, depression, anxiety, irritability, suicidal thoughts
  If yes, please explain _____
- **Endocrine:** Cold or heat intolerance, hot flashes, increased thirst, night sweats
  If yes, please explain _____
- **Hematology:** Enlarged lymph node, excessive bruising, prolonged bleeding
  If yes, please explain _____

Patient Signature _____ Date _____

Patient Signature ____ Date _________________