DALLAS
ALLERGY
&ASTHMA
CENTER

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Name: _____ DOB: _____ Date: _____

## REVIEW OF SYSTEMS QUESTIONNAIRE

Are you **CURRENTLY** experiencing any of the following:

| | | | | | |
|---|---|---|---|---|---|
| **General:** | | **Skin:** | | **Head / Neck:** | |
| Weight change | Y / N | Rash | Y / N | Swelling | Y / N |
| Fatigue | Y / N | Itching | Y / N | Pain | Y / N |
| Night Sweats | Y / N | Hair / Nail Changes | Y / N | Sinus Pressure | Y / N |
| Trouble sleeping | Y / N | | | Post nasal drip | Y / N |
| **Mouth / Throat:** | | **Eyes:** | | **Nose:** | |
| Sore | Y / N | Double vision | Y/ N | Congestion | Y / N |
| Lesions | Y / N | Blurred vision | Y/ N | Runny nose | Y / N |
| Swelling | Y / N | Itching | Y/ N | Bleeding | Y / N |
| Voice changes | Y / N | Watery | Y/ N | Reduced sense of smell | Y / N |
| Throat tightness | Y / N | Red | Y/ N | Itching | Y / N |
| **Ears:** | | **Pulmonary:** | | **Musculoskeletal:** | |
| Popping | Y / N | Cough | Y / N | Joint aches | Y / N |
| Ringing | Y / N | Chest tightness | Y / N | Joint swelling | Y / N |
| Decreased hearing | Y / N | Wheezing | Y / N | Muscle aches | Y / N |
| | | Shortness of breath | Y / N | Stiffness | Y / N |
| **Genitourinary:** | | **Gastrointestinal:** | | **Cardiovascular:** | |
| Pain with urination | Y / N | Trouble swallowing | Y / N | Chest pain | Y / N |
| Blood in urine | Y / N | Heartburn | Y / N | Chest tightness | Y / N |
| Urinary frequency | Y / N | Nausea | Y / N | Palpitations | Y / N |
| Urinary urgency | Y / N | Vomiting | Y / N | Lower extremity swelling | Y / N |
| | | Bloating | Y / N | | |
| | | Diarrhea | Y / N | | |
| **Neurologic:** | | | | | |
| Headaches | Y / N | Current smoker | Y / N | | |
| Light headedness | Y / N | Flu shot this season | Y / N | | |
| Dizziness | Y / N | | | | |

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