



Name: _____ DOB: _____ Date: _____

REVIEW OF SYSTEMS QUESTIONNAIRE

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

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