Review of Systems Questionnaire

CareMEDICA Primary Care

(203) 672-2800

Name: _____

Date of Birth: _____ **Date:** _____

Are you currently experiencing any of the following? Please check all that apply:

General

____ Fatigue
____ Loss of appetite
____ Weakness
____ Fever / Chills
____ Weight Change

ENT / Respiratory

____ Cough
____ Sinus Pressure
____ Nose Bleed
____ Difficulty Breathing
____ Chest tightness
____ Post Nasal Drip
____ Ringing in the Ears

Cardiology

____ Chest Pain
____ Leg Pains
____ Shortness of Breath
____ Diaphoresis (excessive sweating)
____ Palpitations
____ Syncope (fainting)

Gastroenterology

____ Abdominal Pain
____ Constipation

____ Blood in stool
____ Difficulty Swallowing
____ Nausea
____ Vomiting

(FOR MALES ONLY) Genitourinary

____ Increased Urinary Frequency
____Decreased Force in Urination Stream
____ Blood in urine
____ Penile Discharge
____ Burning Urination
____ Urine Odor
____ Nocturia (waking up more than once in the middle of the night to urinate)

(FOR FEMALES ONLY) Genitourinary

____ Blood in Urine
____Decreased Force in Urination Stream
____ Urine Odor
____ Burning Urination
____ Increased Urinary Frequency
____ Nocturia (waking up more than once in the middle of the night to urinate)

Neurology

____ Headache
____ Seizure
____ Tremors
____ Fainting/Blackouts
____ Paresthesias (feeling of tingling or numbness)
____ Memory Impairment
____ Weakness

Musculoskeletal

____ Joint Swelling
____ Arthralgias (joint pain)
____ Leg Cramps
____ Muscle Weakness

Psychology

____ Depression
____ Anxiety
____ Irritability
____ Sleep Disturbances
____ Mood Swings

Endocrinology

____ Increased Hair Growth
____ Polyphagia (extreme, insatiable hunger)
____ Polydipsia (excessive thirst)
____ Dry Skin, Brittle Nails

Ophthalmology

____ Diminished Vision
____ Drainage from Eyes
____ Eye Irritation

Dermatology

____ Discoloration of Skin

____ Varicose Vein

Are there any other symptoms or concerns you'd like to mention?

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