Patient Name: _____ DOB: ____/____/_____ Date: ____/____/_____

Review of Systems

Please review this list of common symptoms and check "Yes" if you are currently having (or occasionally having) the noted symptom. On yes answers, please comment on severity, frequency and triggers.

If you would like to deal with any symptoms or on-going medical conditions today which fall outside of a standard *annual wellness visit,* there will likely be an additional *office visit charge,* which may require a co-pay or deductible. Please check here ___ if you prefer to ONLY do a wellness check-up today and *not* deal with medical issues or symptoms. Please complete the checklist either way. Your signature confirms your understanding:

X_____

Yes	No	Symptom	Comments
☐	☐	- fatigue (feeling tired or poorly)	
☐	☐	- dizziness	
☐	☐	- lightheadedness	
☐	☐	- fever	
☐	☐	- chills	
☐	☐	- muscle aches	
☐	☐	- headaches	
☐	☐	- vision problems	
☐	☐	- loss of hearing	
☐	☐	- earache	
☐	☐	- sore throat	
☐	☐	- chest pains or discomfort	
☐	☐	- palpitations (racing, pounding or irregular heartbeats)	
☐	☐	- coughing	
☐	☐	- wheezing	
☐	☐	- shortness of breath	
☐	☐	- breast lump	
☐	☐	- difficulty swallowing	
☐	☐	- heartburn	
☐	☐	- stomach pain	
☐	☐	- nausea	
☐	☐	- vomiting	
☐	☐	- diarrhea	
☐	☐	- constipation	
☐	☐	- changes in your stool	
☐	☐	- blood in the stool	
☐	☐	- urinary symptoms	
☐	☐	- for men, erection difficulties	
☐	☐	- genital lesions or wart	
☐	☐	- sexual concerns	
☐	☐	- temperature intolerance	
☐	☐	- hot flashes	
☐	☐	- skin lesions/rashes	
☐	☐	- unusual or changing moles	
☐	☐	- diffuse joint pains	
☐	☐	- localized joint pain or issue	
☐	☐	- pain in your calves with exercise	
☐	☐	- anxiety	
☐	☐	- depression	
☐	☐	- insomnia or poor sleep	
☐	☐	- numbness or sensory problem on the skin	
☐	☐	- weakness in your extremities	
☐	☐	- tingling of the skin	
☐	☐	- year of last colonoscopy (if age 50+): _____	
☐	☐	- for female, year of: last PAP: _____; last mammogram (if age 40+): _____	
☐	☐	- other symptom(s) not listed: _____	