

CHECKLIST: Review of Systems

Checklist:

General-

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|--|--|---|
| <input type="checkbox"/> Weight loss or gain | <input type="checkbox"/> Fever or chills | <input type="checkbox"/> Trouble sleeping |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Weakness | |
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Skin-

- | | | |
|---------------------------------|----------------------------------|--|
| <input type="checkbox"/> Rashes | <input type="checkbox"/> Itching | <input type="checkbox"/> Color changes |
| <input type="checkbox"/> Lumps | <input type="checkbox"/> Dryness | <input type="checkbox"/> Hair and nail changes |
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Head-

- | | |
|-----------------------------------|--------------------------------------|
| <input type="checkbox"/> Headache | <input type="checkbox"/> Head injury |
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Ears-

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|---|-----------------------------------|
| <input type="checkbox"/> Decreased hearing | <input type="checkbox"/> Earache |
| <input type="checkbox"/> Ringing in ears (tinnitus) | <input type="checkbox"/> Drainage |
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Eyes-

- | | | |
|--|--|--|
| <input type="checkbox"/> Vision | <input type="checkbox"/> Blurry or double vision | <input type="checkbox"/> Cataracts |
| <input type="checkbox"/> Glasses or contacts | <input type="checkbox"/> Flashing lights | <input type="checkbox"/> Last eye exam |
| <input type="checkbox"/> Pain | <input type="checkbox"/> Specks | |
| <input type="checkbox"/> Redness | <input type="checkbox"/> Glaucoma | |
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Nose-

- | | | |
|-------------------------------------|------------------------------------|-------------------------------------|
| <input type="checkbox"/> Stuffiness | <input type="checkbox"/> Itching | <input type="checkbox"/> Nosebleeds |
| <input type="checkbox"/> Discharge | <input type="checkbox"/> Hay fever | <input type="checkbox"/> Sinus pain |
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Throat-

- | | | |
|-----------------------------------|--------------------------------------|--|
| <input type="checkbox"/> Teeth | <input type="checkbox"/> Sore tongue | <input type="checkbox"/> Thrush |
| <input type="checkbox"/> Gums | <input type="checkbox"/> Dry mouth | <input type="checkbox"/> Non-healing sores |
| <input type="checkbox"/> Bleeding | <input type="checkbox"/> Sore throat | <input type="checkbox"/> Last dental exam |
| <input type="checkbox"/> Dentures | <input type="checkbox"/> Hoarseness | |
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Neck-

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|---|------------------------------------|
| <input type="checkbox"/> Lumps | <input type="checkbox"/> Pain |
| <input type="checkbox"/> Swollen glands | <input type="checkbox"/> Stiffness |
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Breasts-

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|--------------------------------|-------------------------------------|---|
| <input type="checkbox"/> Lumps | <input type="checkbox"/> Discharge | <input type="checkbox"/> Breast-feeding |
| <input type="checkbox"/> Pain | <input type="checkbox"/> Self-exams | |
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Respiratory-

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|---|---|--|
| <input type="checkbox"/> Cough (dry or wet, productive) | <input type="checkbox"/> Coughing up blood (hemoptysis) | <input type="checkbox"/> Wheezing |
| <input type="checkbox"/> Sputum (color and amount) | <input type="checkbox"/> Shortness of breath (dyspnea) | <input type="checkbox"/> Painful breathing |

Cardiovascular-

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|--|--|--|
| <input type="checkbox"/> Chest pain or discomfort | <input type="checkbox"/> Difficulty breathing lying down (orthopnea) | <input type="checkbox"/> Sudden awakening from sleep with shortness of breath (Paroxysmal Nocturnal Dyspnea) |
| <input type="checkbox"/> Tightness | <input type="checkbox"/> Swelling (edema) | |
| <input type="checkbox"/> Palpitations | | |
| <input type="checkbox"/> Shortness of breath with activity (dyspnea) | | |
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Gastrointestinal-

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|--|---|---|
| <input type="checkbox"/> Swallowing difficulties | <input type="checkbox"/> Change in bowel habits | <input type="checkbox"/> Yellow eyes or skin (jaundice) |
| <input type="checkbox"/> Heartburn | <input type="checkbox"/> Rectal bleeding | |
| <input type="checkbox"/> Change in appetite | <input type="checkbox"/> Constipation | |
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Diarrhea | |
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Urinary-

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|--|---|---|
| <input type="checkbox"/> Frequency | <input type="checkbox"/> Blood in urine (hematuria) | <input type="checkbox"/> Change in urinary strength |
| <input type="checkbox"/> Urgency | <input type="checkbox"/> Incontinence | |
| <input type="checkbox"/> Burning or pain | | |
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Genital-**Male-**

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|---|---|--------------------------------|
| <input type="checkbox"/> Pain with sex | <input type="checkbox"/> Sores | <input type="checkbox"/> STD's |
| <input type="checkbox"/> Hernia | <input type="checkbox"/> Masses or pain | |
| <input type="checkbox"/> Penile discharge | <input type="checkbox"/> Erectile dysfunction | |

Female-

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|--|--|--|
| <input type="checkbox"/> Pain with sex | <input type="checkbox"/> Hot flashes | <input type="checkbox"/> Itching or rash |
| <input type="checkbox"/> Vaginal dryness | <input type="checkbox"/> Vaginal discharge | <input type="checkbox"/> STD's |
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Vascular-

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| <input type="checkbox"/> Calf pain with walking (Claudication) | <input type="checkbox"/> Leg cramping |
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Musculoskeletal-

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|---|--|---|
| <input type="checkbox"/> Muscle or joint pain | <input type="checkbox"/> Back pain | <input type="checkbox"/> Swelling of joints |
| <input type="checkbox"/> Stiffness | <input type="checkbox"/> Redness of joints | <input type="checkbox"/> Trauma |
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Neurologic-

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|------------------------------------|-----------------------------------|---------------------------------|
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Weakness | <input type="checkbox"/> Tremor |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Numbness | |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Tingling | |
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Hematologic-

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|---|---|
| <input type="checkbox"/> Ease of bruising | <input type="checkbox"/> Ease of bleeding |
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Endocrine-

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|---|--|--|
| <input type="checkbox"/> Head or cold intolerance | <input type="checkbox"/> Frequent urination (polyuria) | <input type="checkbox"/> Change in appetite (polyphagia) |
| <input type="checkbox"/> Sweating | <input type="checkbox"/> Thirst (polydypsia) | |
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Psychiatric-

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|--------------------------------------|--------------------------------------|---------------------------------|
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Memory loss | <input type="checkbox"/> Stress |
| <input type="checkbox"/> Depression | | |