Review of Systems

Have you recently had or do you now have any of the following symptoms:

on	_	a. 1 .
S .	_	Stomach pain
Loss of hearing		Ulcers
Ear pain		Stool incontinence
Hoarseness		Frequent loose stool
Nose bleeds		bloody stools
Difficulty swallowing		Frequent constipation
Morning cough		Hemorrhoids
Shortness of breath		Frequent urination
Chills or fever		Burning with urination
Heart or chest pain		Urinary incontinence
Abnormal heartbeat		Difficulty starting urination
Frequent headaches		Difficulty stopping urination
Badly swollen ankles		Getting up at night to urinate
Leg cramps when walking		Frequent rash
Poor appetite		Hot or cold spells
Toothache		Recent weight change
Nausea or vomiting		Anxiety
Insomnia		Depression
Poor sleep due to pain		Breast lump
Poor sleep unrelated to pain		Nipple discharge
Other (Specify)		
Women Only		
☐ Irregular periods ☐ Unusual vaginal discharge ☐ Frequent Spotting		
	Hoarseness Nose bleeds Difficulty swallowing Morning cough Shortness of breath Chills or fever Heart or chest pain Abnormal heartbeat Frequent headaches Badly swollen ankles Leg cramps when walking Poor appetite Toothache Nausea or vomiting Insomnia Poor sleep due to pain Poor sleep unrelated to pain Other (Specify)	Loss of hearing Ear pain Hoarseness Nose bleeds Difficulty swallowing Morning cough Shortness of breath Chills or fever Heart or chest pain Abnormal heartbeat Frequent headaches Badly swollen ankles Leg cramps when walking Poor appetite Toothache Nausea or vomiting Insomnia Poor sleep due to pain Poor sleep unrelated to pain Other (Specify)