UNIVERSITY NEUROSCIENCE

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Name Date:

REVIEW OF SYSTEMS WORKSHEET

PLEASE CIRCLE ANY OF THE FOLLOWING SYMPTOMS YOU ARE EXPERIENCING TODAY:

(CONSTITUTIONAL): fatigue, fever, night sweats

(HEENT): eye discharge and vision loss, ear drainage, hearing loss, nasal drainage

(RESPIRATORY): cough, shortness of breath, wheezing

(CARDIOVASCULAR): chest pain, pain in legs when walking, irregular heartbeat/palpitations

(GASTROINTESTINAL): abdominal pain, constipation, diarrhea, vomiting

(GENITOURINARY): painful urination, blood in urine, penile/vaginal discharge, excessive urination

(METABOLIC/ENDOCRINE): cold intolerance, heat intolerance, excessive thirst, excessive eating

(NEURO/PSYCHIATRIC): weakness,gait, disturbance, headache, numbness/tingling, anxiety, depression

(DERMATOLOGIC): itching, rash

(MUSCULOSKELETAL): back pain, bone/joint symptoms, joint swelling, muscle weakness, neck stiffness

(HEMATOLOGY): easy bleeding, easy bruising

(IMMUNOLOGY): environmental allergies, food allergies

IF you are experiencing pain, rate it from 1-10:

1 2 3 4 5 6 7 8 9 10

(No Pain) (Extreme Pain)