

Patient Name: \_\_\_\_\_

DOB: \_\_\_\_\_

**Review of Systems (Male):**

Constitutional:

- | Yes                      | No                       |                             |
|--------------------------|--------------------------|-----------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Change in activity          |
| <input type="checkbox"/> | <input type="checkbox"/> | Change in appetite          |
| <input type="checkbox"/> | <input type="checkbox"/> | Chills                      |
| <input type="checkbox"/> | <input type="checkbox"/> | Excessive sweating          |
| <input type="checkbox"/> | <input type="checkbox"/> | Fatigue                     |
| <input type="checkbox"/> | <input type="checkbox"/> | Fever                       |
| <input type="checkbox"/> | <input type="checkbox"/> | Unexpected weight<br>Change |

Head/Ears/Nose/Throat:

- |                          |                          |                    |
|--------------------------|--------------------------|--------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Congestion         |
| <input type="checkbox"/> | <input type="checkbox"/> | Dental problem     |
| <input type="checkbox"/> | <input type="checkbox"/> | Drooling           |
| <input type="checkbox"/> | <input type="checkbox"/> | Ear discharge      |
| <input type="checkbox"/> | <input type="checkbox"/> | Ear pain           |
| <input type="checkbox"/> | <input type="checkbox"/> | Facial swelling    |
| <input type="checkbox"/> | <input type="checkbox"/> | Hearing loss       |
| <input type="checkbox"/> | <input type="checkbox"/> | Mouth sores        |
| <input type="checkbox"/> | <input type="checkbox"/> | Nosebleeds         |
| <input type="checkbox"/> | <input type="checkbox"/> | Postnasal drip     |
| <input type="checkbox"/> | <input type="checkbox"/> | Rhinorrhea         |
| <input type="checkbox"/> | <input type="checkbox"/> | Sinus pain         |
| <input type="checkbox"/> | <input type="checkbox"/> | Sinus pressure     |
| <input type="checkbox"/> | <input type="checkbox"/> | Sneezing           |
| <input type="checkbox"/> | <input type="checkbox"/> | Sore throat        |
| <input type="checkbox"/> | <input type="checkbox"/> | Ringing in ears    |
| <input type="checkbox"/> | <input type="checkbox"/> | Trouble swallowing |
| <input type="checkbox"/> | <input type="checkbox"/> | Voice change       |

Eyes:

- |                          |                          |                    |
|--------------------------|--------------------------|--------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Eye Discharge      |
| <input type="checkbox"/> | <input type="checkbox"/> | Eye Itching        |
| <input type="checkbox"/> | <input type="checkbox"/> | Eye pain           |
| <input type="checkbox"/> | <input type="checkbox"/> | Eye redness        |
| <input type="checkbox"/> | <input type="checkbox"/> | Photophobia        |
| <input type="checkbox"/> | <input type="checkbox"/> | Visual disturbance |

Respiratory:

- |                          |                          |                     |
|--------------------------|--------------------------|---------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Apnea               |
| <input type="checkbox"/> | <input type="checkbox"/> | Chest tightness     |
| <input type="checkbox"/> | <input type="checkbox"/> | Choking             |
| <input type="checkbox"/> | <input type="checkbox"/> | Cough               |
| <input type="checkbox"/> | <input type="checkbox"/> | Shortness of breath |
| <input type="checkbox"/> | <input type="checkbox"/> | Wheezing            |

Cardiovascular:

- |                          |                          |              |
|--------------------------|--------------------------|--------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Chest pain   |
| <input type="checkbox"/> | <input type="checkbox"/> | Leg swelling |
| <input type="checkbox"/> | <input type="checkbox"/> | Palpitations |

Gastrointestinal:

- |                          |                          |                            |
|--------------------------|--------------------------|----------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Abdominal distention       |
| <input type="checkbox"/> | <input type="checkbox"/> | Abdominal pain             |
| <input type="checkbox"/> | <input type="checkbox"/> | Bright red blood in stools |
| <input type="checkbox"/> | <input type="checkbox"/> | Black stools               |
| <input type="checkbox"/> | <input type="checkbox"/> | Constipation               |
| <input type="checkbox"/> | <input type="checkbox"/> | Diarrhea                   |
| <input type="checkbox"/> | <input type="checkbox"/> | Nausea                     |
| <input type="checkbox"/> | <input type="checkbox"/> | Rectal pain                |
| <input type="checkbox"/> | <input type="checkbox"/> | Vomiting                   |
| <input type="checkbox"/> | <input type="checkbox"/> | Colon polyps               |
| <input type="checkbox"/> | <input type="checkbox"/> | Heartburn                  |
| <input type="checkbox"/> | <input type="checkbox"/> | Hemorrhoids                |

Endocrine:

- |                          |                          |                                   |
|--------------------------|--------------------------|-----------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Cold intolerance                  |
| <input type="checkbox"/> | <input type="checkbox"/> | Heat intolerance                  |
| <input type="checkbox"/> | <input type="checkbox"/> | Excessive/abnormal thirst         |
| <input type="checkbox"/> | <input type="checkbox"/> | Hunger not satisfied by<br>eating |
| <input type="checkbox"/> | <input type="checkbox"/> | Excessive urination               |

Genitourinary:

- |                          |                          |                      |
|--------------------------|--------------------------|----------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty urinating |
| <input type="checkbox"/> | <input type="checkbox"/> | Painful urination    |
| <input type="checkbox"/> | <input type="checkbox"/> | Painful intercourse  |
| <input type="checkbox"/> | <input type="checkbox"/> | Flank pain           |
| <input type="checkbox"/> | <input type="checkbox"/> | Urinary frequency    |
| <input type="checkbox"/> | <input type="checkbox"/> | Genital sore         |
| <input type="checkbox"/> | <input type="checkbox"/> | Blood in urine       |
| <input type="checkbox"/> | <input type="checkbox"/> | Penile discharge     |
| <input type="checkbox"/> | <input type="checkbox"/> | Penile pain          |
| <input type="checkbox"/> | <input type="checkbox"/> | Penile swelling      |
| <input type="checkbox"/> | <input type="checkbox"/> | Scrotal swelling     |
| <input type="checkbox"/> | <input type="checkbox"/> | Testicular pain      |
| <input type="checkbox"/> | <input type="checkbox"/> | Urinary urgency      |
| <input type="checkbox"/> | <input type="checkbox"/> | Decreased urine      |

Musculoskeletal:

- |                          |                          |              |
|--------------------------|--------------------------|--------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Arthralgia   |
| <input type="checkbox"/> | <input type="checkbox"/> | Back pain    |
| <input type="checkbox"/> | <input type="checkbox"/> | Gait problem |

- |                          |                          |                |
|--------------------------|--------------------------|----------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Joint swelling |
| <input type="checkbox"/> | <input type="checkbox"/> | Myalgia        |
| <input type="checkbox"/> | <input type="checkbox"/> | Neck pain      |
| <input type="checkbox"/> | <input type="checkbox"/> | Neck stiffness |

Skin:

- |                          |                          |               |
|--------------------------|--------------------------|---------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Color change  |
| <input type="checkbox"/> | <input type="checkbox"/> | Pallor (Pale) |
| <input type="checkbox"/> | <input type="checkbox"/> | Rash          |
| <input type="checkbox"/> | <input type="checkbox"/> | Wound         |

Allergy/Immunology:

- |                          |                          |                         |
|--------------------------|--------------------------|-------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Environmental allergies |
| <input type="checkbox"/> | <input type="checkbox"/> | Food allergies          |
| <input type="checkbox"/> | <input type="checkbox"/> | Immunocompromised       |

Neurological:

- |                          |                          |                   |
|--------------------------|--------------------------|-------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Dizziness         |
| <input type="checkbox"/> | <input type="checkbox"/> | Facial asymmetry  |
| <input type="checkbox"/> | <input type="checkbox"/> | Headaches         |
| <input type="checkbox"/> | <input type="checkbox"/> | Light-headedness  |
| <input type="checkbox"/> | <input type="checkbox"/> | Numbness          |
| <input type="checkbox"/> | <input type="checkbox"/> | Seizures          |
| <input type="checkbox"/> | <input type="checkbox"/> | Speech difficulty |
| <input type="checkbox"/> | <input type="checkbox"/> | Syncope           |
| <input type="checkbox"/> | <input type="checkbox"/> | Tremors           |
| <input type="checkbox"/> | <input type="checkbox"/> | Weakness          |

Hematologic:

- |                          |                          |                       |
|--------------------------|--------------------------|-----------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Adenopathy            |
| <input type="checkbox"/> | <input type="checkbox"/> | Bruises/bleeds easily |

Psychiatric:

- |                          |                          |                         |
|--------------------------|--------------------------|-------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Agitation               |
| <input type="checkbox"/> | <input type="checkbox"/> | Behavior problem        |
| <input type="checkbox"/> | <input type="checkbox"/> | Confusion               |
| <input type="checkbox"/> | <input type="checkbox"/> | Decreased concentration |
| <input type="checkbox"/> | <input type="checkbox"/> | Depression              |
| <input type="checkbox"/> | <input type="checkbox"/> | Hallucinations          |
| <input type="checkbox"/> | <input type="checkbox"/> | Hyperactive             |
| <input type="checkbox"/> | <input type="checkbox"/> | Nervous/anxious         |
| <input type="checkbox"/> | <input type="checkbox"/> | Self-injury             |
| <input type="checkbox"/> | <input type="checkbox"/> | Sleep disturbance       |
| <input type="checkbox"/> | <input type="checkbox"/> | Suicidal ideas          |