UTSouthwestern

Medical Center

General Outpatient Clinic Review of Systems

Pt. Name:									
Address:									
City	State	Zip							
MRN:		, and the second							
DOB:		SEX:							

Are you experiencing any of the following, either on a regular basis or as a new symptom since your last visit?

YES	NO		YES	NO		YES	NO	
		Constitutional	100		Cardiovascular			Musculoskeletal
0	0	Fever	0	0	Chest Pain	0	0	Muscle pain
0	0	Chills	0	0	Palpitations	0	0	Neck pain
0	0	Weight loss	0	0	Leg (or ankle) swelling	0	0	Back pain
0	0	Weight gain	0	0	Severe shortness of breath	0	0	Joint pain
0	0	Fatigue			which awakens you from sleep	0	0	Falls
0	0	Excessive sweating	0	0	Difficulty breathing when lying flat			Allergy / Endocrinology
0	0	Night sweats			Respiratory	0	0	Environmental allergies
0	0	General weakness	0	0	Cough	0	0	Seasonal allergies
0	0	Hot flashes	0	0	Coughing up blood	0	0	Excessive (frequent) thirst
		Skin	0	0	Coughing up sputum/mucus	0	0	Heat intolerance
0	0	Rash	0	0	Shortness of breath	0	0	Cold intolerance
0	0	Itching	0	0	Wheezing	0	0	Easily bruise or bleed
0	0	Change in mole(s)	0	0	Noisy or high-pitched breathing			Neurological
0	0	Unusual hair loss	0	0	Pain with breathing	0		Dizziness
0	0	Breast concerns			Gastrointestinal	0	0	Tremors
		Head	0		Heartburn	0	0	Sensory change
0	0	Headaches	0	0	Change in appetite			(Numbness, tingling)
0	0	Difficulty hearing	0	0	Nausea	0	0	Speech change
0	0	Ringing in ears	0	0	Vomiting	0	0	Weakness in a specific location
0	0	Ear discharge	0	0	Abdominal pain			(one arm, leg, or other area)
0	0	Ear pain	0	0	Diarrhea	0	0	Seizures
0	0	Nosebleeds	0	0	Constipation	0	0	Loss of consciousness
0	0	Nasal congestion	0	0	Blood in stool			Mental and emotional
0	0	Loss of smell	0	0	Black stool	0	0	Substance abuse
0	0	Snoring	0	0	Incontinence of stool	0	0	Hallucinations
0	0	Difficulty swallowing			Genitourinary / Urogenital	0	0	Feeling nervous or anxious
0	0	Sore throat	0	0	Urgent/sudden need to urinate	0	0	Insomnia
0	0	Mouth sores	0	0	Blood in urine	0	0	Memory lapses or loss
		Eyes	0	0	Painful or burning urination	0	0	Depression
0	0	Blurred vision	0	0	Frequent need to urinate			OTHER CONCERNS
0	0	Double vision	0	0	Need to get up at night to urinate			
0	0	Light sensitivity	0	0	Loss of bladder control		D2 10	
0	0	Eye pain	0	0	Sexual difficulties			
0	0	Eye discharge	0	0	WOMEN: Vaginal discharge	¢- n-		
0	0	Redness	0	0	WOMEN: Vaginal concerns			
	10		0	0	MEN: Penile discharge			

