Name: _____ Date of Birth: _____

Memorial Medical Group
a service of Comanche County Memorial Hospital

Review of Systems

Have you had any of the following symptoms lately?

General

Fatigue	O Yes	O No
Fever	O Yes	O No
Weight loss	O Yes	O No
Chills	O Yes	O No

Eyes

Blurred vision	O Yes	O No
Vision changes	O Yes	O No

Ears

Ear pain	O Yes	O No
Hearing loss	O Yes	O No

Nose, Throat

Nasal congestion	O Yes	O No
Bloody nose	O Yes	O No

Lungs

Shortness of Breath	O Yes	O No
Cough	O Yes	O No
Wheezing	O Yes	O No

Heart

Chest pain	O Yes	O No
Shortness of breath While sleeping	O Yes	O No

Breasts

Drainage from nipple	O Yes	O No
Breast lump	O Yes	O No

Gastrointestinal

Nausea	O Yes	O No
Vomiting	O Yes	O No
Changes in bowels	O Yes	O No
Diarrhea	O Yes	O No
Constipation	O Yes	O No
Blood in stool	O Yes	O No

Urinary

Frequent urination	O Yes	O No
Painful urination	O Yes	O No
Blood in urine	O Yes	O No
Urinary leakage	O Yes	O No

Gynecological (women only)

Vaginal discharge	O Yes	O No
Abnormal vaginal bleeding	O Yes	O No
Menstrual problems	O Yes	O No
Pelvic pain	O Yes	O No

Hematologic

Bruises easily	O Yes	O No
Prolonged bleeding	O Yes	O No

Musculoskeletal

Joint pain	O Yes	O No
Muscle pain	O Yes	O No
Back pain	O Yes	O No

Skin

Skin rash	O Yes	O No
Itching	O Yes	O No

Neurological

Headaches	O Yes	O No
Dizziness	O Yes	O No
Numbness	O Yes	O No

Psychiatric

Difficulty sleeping	O Yes	O No
Feeling anxious	O Yes	O No
Feeling depressed	O Yes	O No

Endocrine

Intolerant of cold	O Yes	O No
Intolerant of heat	O Yes	O No