UTSouthwestern
Medical Center

General Outpatient Clinic
Review of Systems

Pt. Name: ______________________________
Address: ______________________________
____
City State Zip
MRN: ______________________________
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	
		Constitutional
O	O	Fever
O	O	Chills
O	O	Weight loss
O	O	Weight gain
O	O	Fatigue
O	O	Excessive sweating
O	O	Night sweats
O	O	General weakness
O	O	Hot flashes
		Skin
O	O	Rash
O	O	Itching
O	O	Change in mole(s)
O	O	Unusual hair loss
O	O	Breast concerns
		Head
O	O	Headaches
O	O	Difficulty hearing
O	O	Ringing in ears
O	O	Ear discharge
O	O	Ear pain
O	O	Nosebleeds
O	O	Nasal congestion
O	O	Loss of smell
O	O	Snoring
O	O	Difficulty swallowing
O	O	Sore throat
O	O	Mouth sores
		Eyes
O	O	Blurred vision
O	O	Double vision
O	O	Light sensitivity
O	O	Eye pain
O	O	Eye discharge
O	O	Redness

YES	NO	
		Cardiovascular
O	O	Chest Pain
O	O	Palpitations
O	O	Leg (or ankle) swelling
O	O	Severe shortness of breath which awakens you from sleep
O	O	Difficulty breathing when lying flat
		Respiratory
O	O	Cough
O	O	Coughing up blood
O	O	Coughing up sputum/mucus
O	O	Shortness of breath
O	O	Wheezing
O	O	Noisy or high-pitched breathing
O	O	Pain with breathing
		Gastrointestinal
O	O	Heartburn
O	O	Change in appetite
O	O	Nausea
O	O	Vomiting
O	O	Abdominal pain
O	O	Diarrhea
O	O	Constipation
O	O	Blood in stool
O	O	Black stool
O	O	Incontinence of stool
		Genitourinary / Urogenital
O	O	Urgent/sudden need to urinate
O	O	Blood in urine
O	O	Painful or burning urination
O	O	Frequent need to urinate
O	O	Need to get up at night to urinate
O	O	Loss of bladder control
O	O	Sexual difficulties
O	O	**WOMEN:** Vaginal discharge
O	O	**WOMEN:** Vaginal concerns
O	O	**MEN**: Penile discharge

YES	NO	
		Musculoskeletal
O	O	Muscle pain
O	O	Neck pain
O	O	Back pain
O	O	Joint pain
O	O	Falls
		Allergy / Endocrinology
O	O	Environmental allergies
O	O	Seasonal allergies
O	O	Excessive (frequent) thirst
O	O	Heat intolerance
O	O	Cold intolerance
O	O	Easily bruise or bleed
		Neurological
O	O	Dizziness
O	O	Tremors
O	O	Sensory change *(Numbness, tingling)*
O	O	Speech change
O	O	Weakness in a specific location *(one arm, leg, or other area)*
O	O	Seizures
O	O	Loss of consciousness
		Mental and emotional
O	O	Substance abuse
O	O	Hallucinations
O	O	Feeling nervous or anxious
O	O	Insomnia
O	O	Memory lapses or loss
O	O	Depression
		OTHER CONCERNS