KC Medical Care - REVIEW OF SYSTEMS

Please circle "yes" if symptom is present

NAME:_____ **NO CHANGE SINCE LAST VISIT** ☐

General, constitutional
Poor general health lately ..... yes
Recent weight loss ..... yes
Recent weight gain …….
Fever/ Chills ..... yes
Fatigue ..... yes

Eyes and vision
Eye disease or injury……. yes
Wear glasses or contact lenses ..... yes
Blurred or double vision ..... yes
Glaucoma ..... yes
Pain ……...

Ears, nose, throat
Hearing loss ..... yes
Ringing in the ears ..... yes
Sinus problems ..... yes
Nose bleeds ..... yes
Bleeding gums ..... yes
False teeth .....
Sore throat or voice change..... yes

Genitourinary
Frequent urination…… yes
Burning or painful urination ..... yes
Blood in urine ..... yes
Stones .....
Kidney Disease .....
Sexual difficulty/pain ..... yes
Irregular periods (female) ..... yes
Erectile dysfunction (male) ..... yes

Respiratory
Frequent coughing ..... yes
Spitting up blood ..... yes
Shortness of breath ..... yes

Musculoskeletal
Joint pain ..... yes
Joint stiffness or swelling ..... yes
Weakness of muscles/joints ..... yes
Muscle pain or cramps ..... yes
Back pain ..... yes
Difficulty in walking ..... yes

Skin and breasts
Rash or itching ..... yes
Change in skin color ..... yes
Varicose veins ..... yes
Breast pain ..... yes

Neurological
Frequent or recurrent headaches ..... yes
Lightheaded or dizzy ..... yes
Convulsions or tingling sensations ..... yes
Tremors ..... yes
Strokes / TIA ..... yes
Head injury..... yes

Psychiatric
Memory loss or confusion ..... yes
Nervousness/ anxiety ..... yes
Depression ..... yes
Sleep problems ..... yes
Snoring/ yes
apnea .....

Endocrine
Glandular or hormone problem ..... yes
Thyroid disease ..... yes

Asthma or wheezing..... yes
Sleep Apnea .....

Gastrointestinal /Extremities

Loss of appetite ..... yes

Constipation ..... yes

Nausea or vomiting ..... yes
Indigestion/Heartburn .....

Frequent diarrhea ..... yes

Blood in stool ..... yes

Leg cramps/pain ..... yes

Restless legs ..... yes

Leg ulcers/redness ..... yes

Diabetes ..... yes

Excessive thirst or urination ..... yes

Heat or cold intolerance ..... yes

Hematologic/ Lymphatic

Slow to heal after cuts ..... yes

Easily bruise or bleed ..... yes

Anemia ..... yes

Phlebitis ..... yes

Transfusion ..... yes

Swollen glands ..... yes

PLEASE INDICATE BELOW ONLY IF ARE YOU <u>CURRENTLY</u> EXPERIENCING ANY OF THESE SYMPTOMS:
ANY OTHER PROBLEMS:

Signature:_____ **Date:_____**