Coastal Neurology Services
Patient Review of Systems

Name____________________________ DOB___________ Today's Date__________

Please indicate explanation for any "yes" answers on next page.

Hand dominance: **Right handed___** **Left Handed___**

Constitutional	**NO**	**YES**
Fatigue	___	___
Fever	___	___
Recent weight loss?	___	___
Recent weight gain?	___	___

Eye, Ear and Throat		
Ear drainage	___	___
Ear pain	___	___
Eye discharge	___	___
Eye pain	___	___
Hearing loss	___	___
Nasal discharge	___	___
Sinus pressure	___	___
Sore throat	___	___
Visual changes	___	___
Ringing in ears	___	___
Dry eyes	___	___
Dry mouth	___	___

Respiratory		
Cough	___	___
Known TB exposure	___	___
Shortness of breath	___	___
Wheezing	___	___

Cardiovascular		
Chest pain	___	___
Limb swelling	___	___
Palpitations	___	___
Heart murmur	___	___

Gastrointestinal		
Abdominal pain	___	___
Blood in stools	___	___
Constipation	___	___
Diarrhea	___	___
Heartburn	___	___
Loss of appetite	___	___
Nausea	___	___
Vomiting	___	___
Bloating	___	___

Genitourinary	**NO**	**YES**
Painful Urination	___	___
Blood in urine	___	___
Urinary frequency	___	___
Urinary incontinence	___	___
Urinary urgency	___	___

Reproductive		
Sexually active	___	___
Sexual dysfunction	___	___
Painful periods (female)	___	___
Painful intercourse (female)	___	___
Hot flashes	___	___
Irregular Menses	___	___
Erectile dysfunction	___	___
Testicular mass	___	___
Breast lump	___	___
Breast discharge	___	___

Skin		
Hair loss	___	___
Hair growth changes	___	___
Hives	___	___
Itching	___	___
Pigmentation changes	___	___

Metabolic/Endocrine		
Cold intolerance	___	___
Heat intolerance	___	___
Excessive thirst	___	___
Increased appetite	___	___

Neurological		
Dizziness	___	___
Limb numbness	___	___
Limb weakness	___	___
Gait disturbance	___	___
Headache	___	___
Memory loss	___	___
Seizures	___	___
Tremors	___	___

Patient Review of Systems
Page Two

Name______________________________ DOB__________ Today's Date__________

Please indicate explanation for any "yes" answers below.

Psychiatric	**NO**	**YES**
Anxiety	___	___
Depression	___	___
Insomnia	___	___
Mood swings	___	___
Musculoskeletal		
Back pain	___	___
Joint pain	___	___
Joint swelling	___	___
Muscle weakness	___	___
Neck pain	___	___

Hematologic	**NO**	**YES**
Easy bleeding	___	___
Easy bruising	___	___
Enlarged lymph nodes	___	___
Immunologic		
Contact allergy	___	___
Environmental allergies	___	___
Food allergies	___	___
Seasonal allergies	___	___

Please explain any "yes" answers below