APM SPINE & SPORTS PHYSICIANS

REVIEW OF SYSTEMS

PATIENT NAME: _____ DATE: _____

Please mark any problems you have from the list below.

☐ **No Changes since last visit** ***(Returning Patients only)***

CONSTITUTIONAL ☐ Fever ☐ Weight loss ☐ Weight Gain ☐ Weakness ☐ Fatigue
☐ Difficulty sleeping ☐ Chills ☐ Night sweats

EYES ☐ Visual Problems ☐ Glaucoma

HENT ☐ Headaches ☐ Sinus problems ☐ Hearing problems
☐ Sleep apnea

CARDIOVASCULAR ☐ Heart trouble ☐ Swelling of feet ☐ Hypertension
☐ Lower Extremity Swelling

RESPIRATORY ☐ Cough ☐ Shortness of breath

GASTROINTESTINAL ☐ Liver disease ☐ Hepatitis ☐ Gall Bladder Problems
☐ Reflux ☐ Bowel problems ☐ Constipation ☐ Diarrhea

GENITOURINARY ☐ Kidney stones ☐ Kidney disease ☐ Bladder problems
☐ Blood in urine ☐ Reduced libido (desire for sex)

INTEGUMENT ☐ Dry Skin ☐ Rashes

NEUROLOGICAL ☐ Seizures ☐ Stroke ☐ Peripheral neuropathy
☐ Memory or concentration difficulties ☐ Loss of balance ☐ Falls
☐ Head Injuries ☐ Numbness

MUSCULOSKELETAL ☐ Neck or low back pain ☐ Gout ☐ Hip or Shoulder Pain
☐ Knee pain ☐ Carpal Tunnel Syndrome ☐ Foot or ankle pain

ENDOCRINE ☐ Thyroid problem ☐ Diabetes ☐ Excessive thirst

PSYCHIATRIC ☐ Depression ☐ Anxiety ☐ Anger ☐ Guilt

HEME-LYMPH ☐ Easy bruising ☐ HIV exposure ☐ Bleeding Problems

ALLERGIC-IMMUNOLOGIC ☐ Seasonal Allergy Symptoms
☐ Anaphylactic (severe) Medication Allergies
☐ Anaphylactic (severe) Reaction to Bee Stings

Reviewed By: _____ Date: _____