Coastal Healthcare

Patient Review of Systems — Completed by Patient

Name:_____ Date of Birth: _____

Constitutional Symptoms	Yes	No	Cardiovascular	Yes	No	Respiratory	Yes	No
Fever			Chest Pain			Wheezing		
Chills			Palpitations			Frequent Cough		
Weight Gain			**Musculoskeletal**			Shortness of Breath		
Weight Loss			Joint Pain			**Neurological**		
Fatigue			Back Pain			Headache		
Eyes			Muscle Pains			Tremors/Hands Shaking		
Blurred Vision			**Ear/Nose/Throat/ Mouth**			Dizziness		
Double Vision			Difficulty Swallowing			Numbness/Tingling		
Skin			Ear Infection			**Gastrointestinal**		
Skin Rash			Sore Throat			Abdominal Pain		
Dry Skin			Sinus Problems			Nausea/Vomiting		
Hair Loss			Nose Bleeds			Heartburn		
Endocrine			Swollen Neck Glands			Loss of Appetite		
Excessive Thirst			**Genitourinary**			Diarrhea		
Heat Intolerance			Painful Urination			Constipation		
Cold Intolerence			Frequent Urination			**Psychological**		
Change in Hat/ Glove Size						Depression		
						Insomnia		
						Anxiety		

Patient Signature: _____ Date: _____