Review of Systems – Propst

Please completely fill in the selected bubbles.

Constitutional		
Chills	O Yes	O No
Fever	O Yes	O No
Night/Day sweats	O Yes	O No
Weight loss	O Yes	O No
Weight gain	O Yes	O No

Breast		
Masses	O Yes	O No
Nipple Discharge	O Yes	O No
Axillary Nodes	O Yes	O No

Cardiology		
Chest Tightness	O Yes	O No
Sleep with 3 or more pillows	O Yes	O No
Chest pain	O Yes	O No
Leg swelling	O Yes	O No
Palpitations	O Yes	O No
Shortness of breath	O Yes	O No

Respiratory		
Pain with breathing	O Yes	O No
Coughing blood	O Yes	O No
Productive cough	O Yes	O No
Cough	O Yes	O No
Wheezing	O Yes	O No

Gastroenterology		
Swallowing Difficulty	O Yes	O No
Heartburn	O Yes	O No
Nausea	O Yes	O No
Vomiting	O Yes	O No
Vomiting blood	O Yes	O No
Black/tarry stools	O Yes	O No
Abdominal pain	O Yes	O No
Jaundice	O Yes	O No
Diarrhea	O Yes	O No
Loss of appetite	O Yes	O No

Patient Name :_____ DOB:_____

Review of Systems – Propst

Please completely fill in the selected bubbles.

Musculoskeletal

Swelling in small joints of hands and feet	O Yes	O No
Pain in small joints of hands and feet	O Yes	O No
Swelling in large joints	O Yes	O No
Pain in large joints	O Yes	O No
Fracture	O Yes	O No
Morning Stiffness	O Yes	O No
Great Toe Pain	O Yes	O No
Muscle Cramps	O Yes	O No
Calf pain when walking	O Yes	O No
Muscle wasting	O Yes	O No

Urology

Urinary Frequency	O Yes	O No
Urinary Urgency	O Yes	O No
Inability to urinate	O Yes	O No
Dribbling	O Yes	O No
Increase in amount of urine	O Yes	O No
Stones	O Yes	O No
Discharge	O Yes	O No
Venereal Disease	O Yes	O No
Pelvic Pain	O Yes	O No
Painful Intercourse	O Yes	O No
Blood in Urine	O Yes	O No

Neurology

Periods of Unconsciousness	O Yes	O No
Temporary episodes of leg weakness	O Yes	O No
Temporary episodes of arm weakness	O Yes	O No
Changes of smell	O Yes	O No
Changes of taste	O Yes	O No
Gait Disturbances	O Yes	O No
Blurred Vision	O Yes	O No
Hearing Loss	O Yes	O No
Headache	O Yes	O No
Temporary episodes of blindness	O Yes	O No
Tremor	O Yes	O No

Patient Name :_____ DOB:_____