BLUE RIDGE ASSOCIATES IN NEUROLOGY

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Review of Systems

Patient Name: _____ **Today's Date:** _____

Review of Systems: In the past *month*, have you experienced any of the following:

☐ Fevers	☐ Chills	☐ Sweats	☐ Poor appetite	☐ Fatigue
☐ Too sleepy	☐ Trouble sleeping	☐ Feeling ill	☐ Weight gain	☐ Weight loss
☐ Eye pain	☐ Vision loss	☐ Blurry vision	☐ Double vision	☐ Eye irritation
☐ Eye discharge	☐ Light sensitivity	☐ Ear pain	☐ Ringing in ears	☐ Decreased hearing
☐ Nasal discharge	☐ Nosebleeds	☐ Sore throat	☐ Hoarseness	☐ Trouble swallow
☐ Chest pain	☐ Palpitations	☐ Passing out	☐ Easily winded	☐ Leg swelling
☐ Cough	☐ Bloody sputum	☐ Wheezing	☐ Nausea	☐ Vomiting
☐ Diarrhea	☐ Constipation	☐ Stool incontinence	☐ Abdominal pain	☐ Bloody stool
☐ Pain with urination	☐ Blood in urine	☐ Urine incontinence	☐ Back pain	☐ Joint pain
☐ Joint swelling	☐ Muscle cramps	☐ Muscle pain	☐ Muscle stiffness	☐ Skin rash
☐ Itching	☐ Color change	☐ Hair loss	☐ Dry skin	☐ Weakness
☐ Numbness	☐ Seizures	☐ Tremors	☐ Dizziness	☐ Depression
☐ Anxiety	☐ Memory loss	☐ Suicidal thoughts	☐ Hallucinations	☐ Cold intolerance
☐ Heat intolerance	☐ Excessive thirst	☐ Excessive hunger	☐ Frequent urine	☐ Easy bruising
☐ Easy bleeding	☐ Big lymph nodes	☐ Hives	☐ Hay fever	☐ Ongoing infections

Do you currently smoke? ☐ No, Never ☐ Yes, every day ☐ Yes, some days ☐ No, I quit

Have you had any falls within the past year? ☐ No ☐ Yes; if yes, how many? _____

Have you had a flu shot within the past 12 months? ☐ No ☐ Yes

Have you ever had a pneumonia shot? ☐ No ☐ Yes

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