SWEDISH MEDICAL GROUP

Review of Systems

Name:______________________________ DOB: ____________ Date: ______________

Please **CHECK** below any current symptoms you have: ☐ **None**

General
- ☐ Fever
- ☐ Chills
- ☐ Sweats
- ☐ Weight loss
- ☐ Weight gain
- ☐ Poor appetite
- ☐ Fatigue

Heart
- ☐ Lightheadedness
- ☐ Palpitations
- ☐ Swelling of legs/ankles
- ☐ Chest pain

Lungs
- ☐ Cough
- ☐ Shortness of breath with or without activity

Digestion
- ☐ Nausea
- ☐ Vomiting
- ☐ Change in bowel movements (Frequency, size or shape)
- ☐ Black stools
- ☐ Blood in stools
- ☐ Diarrhea
- ☐ Constipation
- ☐ Abdominal pain

Bladder
- ☐ Increased frequency of urination
- ☐ Painful urination
- ☐ Getting out of bed to urinate
- ☐ Loss of urine with cough or sneeze
- ☐ Blood in urine
- ☐ Sudden urge to urinate
- ☐ Slow stream
- ☐ Incomplete emptying

Joints/Muscles
- ☐ Stiff joints
- ☐ Neck pain
- ☐ Back pain

Skin
- ☐ Rash
- ☐ New or unusual skin lesion
- ☐ Changing mole

Breast
- ☐ Lump
- ☐ Nipple discharge
- ☐ Pain

Neurologic
- ☐ Headaches
- ☐ Seizures

Mood
- ☐ Eating disorder
- ☐ Anxiety
- ☐ Mood swings
- ☐ Depression

During the past month, have you often been bothered by feeling down, depressed, or hopeless? ☐ Y ☐ N

During the past month, have you often been bothered by little interest or pleasure in doing things? ☐ Y ☐ N

Hormonal
- ☐ Excessive urination
- ☐ Excessive thirst
- ☐ Fertility issues
- ☐ Temperature intolerance

Blood
- ☐ Easy bruising
- ☐ Excessive bleeding from nose/gums/cuts
- ☐ Abnormal lymph nodes

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Patient Signature Date