

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:

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

Rev 10/10/20