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

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