Brian E. Novick, M.D.

Irene C Paek, M.D.

DATE__________

NAME______________________________

DATE OF BIRTH__________

Review of Systems

Do you experience any of these symptoms?

GENERAL	Yes	No
Fever		
Night sweats		
Weight loss		
Chills		
Fatigue		
Weight Gain		

EAR/NOSE/THROAT	Yes	No
Dryness of mouth		
Earache		
Hearing loss		
Nasal congestion		
Post nasal drip		
Recurrent sinus problems		
Hoarseness		
Sore throat		

BLADDER/KIDNEYS	Yes	No
Painful urination		
Blood in urine		
Discharge		
Frequent urination		
Trouble urinating		
Nocturia		
Incontinence		
Genital sores		
Decreased libido		
Erectile dysfunction		
Cloudy-smoky urine		
Ulcers		
Sexual difficulties		
Prostate troubles		

SKIN	Yes	No
Skin discoloration		
Rash		

MUSCLES/JOINTS	Yes	No
Muscle cramps		
Muscle pain		
Muscle weakness		
Joint pain		
Joint swelling		
Back pain		
Arthritis		
Stiffness		
Sciatica		
Restless legs		
Leg pain at night		
Leg pain with exertion		

STOMACH/GI	Yes	No
Nausea		
Vomiting		
Heartburn/indigestion		
Abdominal pain		
Abdominal bloating		
Painful/difficulty swallowing		
Belching/sour taste		
Bad morning breath		
Loss of appetite		
Bloody/black stools		

EYES	Yes	No
Vision loss		
Double vision		
Dryness of eyes		

CHEST	Yes	No
Chest pain/discomfort		
Palpitations		
Difficulty breathing while lying down		
Shortness of breath with exertion		
Difficulty breathing at night		

EXTREMITIES	Yes	No
Swelling of hands or feet		

PSYCHOLOGICAL	Yes	No
Depression		
Anxiety		
Memory loss		
Paranoia		
Suicidal ideation		
Hallucinations		
Phobia		
Confusion		
Difficulty falling asleep		
Difficulty staying awake		

ENDOCRINOLOGY	Yes	No
Cold intolerance		
Heat intolerance		
Excessive thirst		
Excessive urination		
Unusual weight change		

HEMATOLOGY	Yes	No
Abnormal bruising		
Enlarged lymph nodes		
Bleeding		
Anemia		
History of transfusion		

#ReviewofSystems

Allergy Testing

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