Skylyn Wellness Center, Inc.
Review of Systems

Patient Name_____ Date_____

Primary Care Provider_____

Please indicate below if you are currently experiencing any of these symptoms:

GENERAL, CONSTITUTIONAL

Good general health lately	No	Yes
Recent weight change	No	Yes
Fever	No	Yes
Fatigue	No	Yes

EYES and VISION

Eye disease or injury	No	Yes
Blurred or double vision	No	Yes
Glaucoma	No	Yes

EARS, NOSE & THROAT

Hearing loss	No	Yes
Ringing in the ears	No	Yes
Nosebleeds	No	Yes
Mouth sores	No	Yes
Bleeding gums	No	Yes
Swollen glands in neck	No	Yes

HEART & CARDIOVASCULAR

Heart trouble	No	Yes
Chest pains	No	Yes
Sudden heartbeat changes	No	Yes
Swelling of feet, ankles, hands	No	Yes

PULMONARY

Frequent cough	No	Yes
Shortness of breath	No	Yes
Asthma or wheezing	No	Yes
Spitting up blood	No	Yes

RESPIRATORY

Frequent coughing	No	Yes
Spitting up blood	No	Yes
Shortness of breath	No	Yes
Asthma or wheezing	No	Yes

GASTROINTERTINAL

Loss of appetite	No	Yes
Change in bowel movement	No	Yes
Nausea/vomiting	No	Yes
Frequent diarrhea	No	Yes
Painful bowel movements or Constipation	No	Yes
Blood in stool	No	Yes
Stomach pain	No	Yes

GENITOURINARY

Frequent urination	No	Yes
Burning or painful urination	No	Yes
Kidney stones	No	Yes
Incontinence or dribbling	No	Yes
Sexual difficulty	No	Yes

IMMUNOLOGIC

Hay fever	No	Yes
HIV	No	Yes
Persistent infection	No	Yes
Urticaria	No	Yes

MUSCULOSKELETAL

Joint pain		No	Yes
Joint stiffness or swelling		No	Yes
Weakness of muscles/joints		No	Yes
Muscle pain or cramps		No	Yes
Neck pain		No	Yes
Upper back pain		No	Yes
Mid back pain		No	Yes
Low back pain		No	Yes
Cold extremities		No	Yes
Difficulty in walking		No	Yes
Arm pain	left	right	bilateral
Sacroiliac joint pain	left	right	bilateral
Difficulty raising arms	left	right	bilateral
Difficulty turning head	left	right	bilateral
Shoulder pain	left	right	bilateral
Leg pain	left	right	bilateral

SKIN

Rash or itching	No	Yes
Change in hair or nails	No	Yes

NEUROLOGICAL

Frequent or recurrent headaches	No	Yes
Light headed or dizzy	No	Yes
Convulsions or seizures	No	Yes
Numbness or tingling	No	Yes
Tremors	No	Yes
Paralysis	No	Yes
Stroke	No	Yes
Head injury	No	Yes

PSYCHIATRIC

Memory loss or confusion	No	Yes
Nervousness	No	Yes
Depression	No	Yes
Sleep problems	No	Yes

ENDOCRINE

Glandular or hormone problem	No	Yes
Thyroid disease	No	Yes
Diabetes	No	Yes
Excessive thirst or urination	No	Yes
Heat or cold intolerance	No	Yes
Dry skin	No	Yes

HEMATOLOGIC/LYMPHATIC

Slow to heal after cuts	No	Yes
Easily bruise or bleed	No	Yes
Anemia	No	Yes
Phlebitis	No	Yes
Transfusion	No	Yes
Swollen glands	No	Yes

If you have not had a hysterectomy, please give the date of your last menstrual period: _____