Review of Systems

PALOMAR HEALTH MEDICAL GROUP
Reimagining Healthcare™

Date_____

Patient Name:_____DOB:_____

Please Mark the symptoms you are currently experiencing or new symptoms within the last 7 days.

CONSTITUTIONAL

- ☐ Temperature Intolerance
- ☐ Fatigue
- ☐ Non-Restorative Sleep
- ☐ Night Sweats
- ☐ Abnormal Weight Gain
- ☐ Abnormal Weight Loss
- ☐ Other:_____

GENITOURINARY

- ☐ Dribbling
- ☐ Slow Stream
- ☐ Frequent Urination
- ☐ Urinary Incontinence
- ☐ Night time Urination (≥2 times a night)
- ☐ Other:_____

HEENT

- ☐ Nasal Congestion
- ☐ Nasal Drainage
- ☐ Sinus Pressure
- ☐ Snoring
- ☐ Other:_____

IMMUNOLOGIC

- ☐ Environmental Allergies
- ☐ Seasonal Allergies
- ☐ Other:_____

NEUROLOGICAL

- ☐ Fainting
- ☐ Headache
- ☐ Memory Loss
- ☐ Seizure
- ☐ Tremors
- ☐ Other:_____

PSYCHIATRIC

- ☐ Anxiety
- ☐ Depression
- ☐ Insomnia
- ☐ Worsening Stress
- ☐ Mood Changes/Irritability
- ☐ Difficulty concentrating during the day
- ☐ Other:_____

RESPIRATORY

- ☐ Chronic Cough
- ☐ Shortness of Breath
- ☐ Wheezing
- ☐ Other:_____

FEMALE

- ☐ Hot Flashes
- ☐ Decreased Libido

MALE

- ☐ Impotence/ED
- ☐ Decreased Libido