FLORIDA
Neurology Group

Review of Systems

Please Check Each Item "YES" or "NO" As They Pertain To Your Current Health

Patient Name _____ **Date** _____

General
Tires Easily ❑ Yes ❑ No
Weight Change
❑ Gained ❑ Lost ❑ Yes ❑ No

Eyes
Cataract ❑ Yes ❑ No
❑ Left ❑ Right ❑ Bilateral ❑ Yes ❑ No
Drooping Eyelids
❑ Left ❑ Right ❑ Bilateral ❑ Yes ❑ No
Glaucoma
❑ Left ❑ Right ❑ Bilateral ❑ Yes ❑ No
Macular Degeneration
❑ Left ❑ Right ❑ Bilateral ❑ Yes ❑ No
Blind Spots ❑ Yes ❑ No
Blurred Vision ❑ Yes ❑ No
Double Vision ❑ Yes ❑ No
Flashing Lights/Wavy Lines ❑ Yes ❑ No
Loss of Vision-Partial ❑ Yes ❑ No
- "Curtain Drawn" ❑
- Lower Half ❑
- Sudden ❑
- Upper Half ❑

Loss of Vision-Total ❑ Yes ❑ No
- Briefly ❑
- Left ❑
- Right ❑
- Bilateral ❑

Ears, Nose & Throat
Difficulty Understanding Speech ❑ Yes ❑ No
Hearing Loss ❑ Yes ❑ No
- Right ❑
- Left ❑
- Bilateral ❑
- Getting Worse ❑

Ringing in Ears (Tinnitus) ❑ Yes ❑ No
- Right ❑
- Left ❑
- Bilateral ❑

Nose Bleeds ❑ Yes ❑ No
- Recurrent ❑

Gum Bleeding ❑ Yes ❑ No
Difficulty Swallowing ❑ Yes ❑ No
Hoarseness ❑ Yes ❑ No

Respiratory
Cough ❑ Yes ❑ No
- Brings Up Blood ❑
- Chronic Cough ❑

Shortness of Breath ❑ Yes ❑ No
Wheezes ❑ Yes ❑ No
- Occasional ❑
- Mild ❑
- Moderate ❑
- Severe ❑

Cardiac
Chest Pain ❑ Yes ❑ No
- Mild ❑
- Moderate ❑
- Severe ❑

Gastrointestinal
Abdominal Pain ❑ Yes ❑ No
Blood in Stool ❑ Yes ❑ No
Constipation ❑ Yes ❑ No
- Chronic ❑

Heartburn ❑ Yes ❑ No
Nausea ❑ Yes ❑ No
- With Vomiting ❑

Genitourinary
Blood in Urine ❑ Yes ❑ No
- Bright Red ❑

Incontinence ❑ Yes ❑ No
Frequent Urination ❑ Yes ❑ No
Urinary Infection ❑ Yes ❑ No
- Recently ❑
- Continues ❑

Kidney Stones ❑ Yes ❑ No

Female Only
- Menstruating ❑ Yes ❑ No
- Postmenopausal ❑ Yes ❑ No
- Premenstrual ❑ Yes ❑ No
- Surgical Menopause ❑ Yes ❑ No

Musculoskeletal
Degenerative Joint Disease ❑ Yes ❑ No
Muscle Stiffness ❑ Yes ❑ No
Back Pain ❑ Yes ❑ No
Muscle Pain ❑ Yes ❑ No
Muscle Weakness ❑ Yes ❑ No

Skin, Breast & Chest
Skin Sensitive to Sunlight ❑ Yes ❑ No
Change in Mole ❑ Yes ❑ No
Jaundice ❑ Yes ❑ No
Rash ❑ Yes ❑ No
Breast Discharge ❑ Yes ❑ No
Breast Enlargement ❑ Yes ❑ No
Breast Lump ❑ Yes ❑ No

Psychiatric
Change in Personality ❑ Yes ❑ No
Compulsive Behavior ❑ Yes ❑ No
Depression ❑ Yes ❑ No
- With Elations ❑
- Comes & Goes ❑

Anxiety ❑ Yes ❑ No
Excessive Sleeping ❑ Yes ❑ No
Insomnia ❑ Yes ❑ No
Sleep Apnea ❑ Yes ❑ No
Stress ❑ Yes ❑ No

Endocrine
Decrease Hair Growth ❑ Yes ❑ No
- Body ❑
- Beard ❑

Excessive Hair Growth ❑ Yes ❑ No
- Body ❑
- Beard ❑

Loss of Hair ❑ Yes ❑ No
- Body ❑
- Beard ❑

Deepening of Voice ❑ Yes ❑ No
Diabetes ❑ Yes ❑ No
Excessive Hunger ❑ Yes ❑ No
Excessive Thirst ❑ Yes ❑ No
Excessive Sweating ❑ Yes ❑ No
Excessive Urination ❑ Yes ❑ No
Eyes Bulging Out ❑ Yes ❑ No
Hot Flashes ❑ Yes ❑ No
Thyroid Problems ❑ Yes ❑ No

Hematology/Lymphatic
Anemia ❑ Yes ❑ No
Bleeds Easily ❑ Yes ❑ No
Bruises Easily ❑ Yes ❑ No
- Spontaneously ❑

Swollen Nodes ❑ Yes ❑ No

Allergic/Immunologic
Hay Fever/Asthma ❑ Yes ❑ No
Chronic Immunity Problems ❑ Yes ❑ No