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