Date: Patient Name: MR#

Questionnaire: Patient Comprehensive Review of Systems. Patient to complete "Yes-No" checklist
Check box for any symptoms you have had in the last 2 weeks, circle the box if you are having today.

Y	SYMPTOM	N
	CONSTITUTIONAL	
	Fever	
	Chills	
	Unexplained weight loss	
	Fatigue or Severe lack of energy	
	Unexplained sweating	
	Weakness	
	SKIN	
	Rash	
	Itching	
	HENT	
	Headaches	
	Hearing loss	
	Ringing in the ears	
	Ear Pain	
	Ear Discharge	
	Nosebleeds	
	Congestion	
	Noisy breathing	
	Sore throat	
	Facial pain	
	Jaw Pain	

Y	SYMPTOM	N
	EYES	
	Blurred Vision	
	Double vision	
	Light hurting your eyes.	
	Eye pain	
	Eye discharge	
	Eye redness	
	CARDIOVASCULAR	
	Chest pain, discomfort or tightness	
	Rapid or irregular heartbeats	
	Short of breath lying down	
	Pain in the leg muscles with walking; no pain at rest	
	Swelling of the leg(s) or ankle(s)	
	Shortness of breath waking you up suddenly at night	
	RESPIRATORY	
	Cough	
	Coughing up blood	
	Coughing up sputum	
	Shortness of breath	
	Wheezing	

Y	SYMPTOM	N
	INTESTINAL	
	Heartburn	
	Nausea	
	Vomiting	
	Vomiting blood	
	Abdominal pain	
	Diarrhea	
	Constipation	
	Blood in stool	
	Black, tar-like or burgundy stool	
	GENITOURINARY	
	Pain on urination	
	Urgency to urinate	
	Increased frequency of urination	
	Blood in urine	
	Pain on your sides (of the stomach)	
	MUSCLES/BONE	
	Muscle aches	
	Neck pain	
	Back pain	
	Joint pain	
	Falls	

Y	SYMPTOM	N
	ENDO/HEME/ ALLERGY	
	Easy bruising	
	Hayfever, sneezing	
	Drinking more than normal.	
	NEUROLOGIC	
	Dizziness	
	Tingling or numbness	
	Tremor or shaking	
	Sensory change	
	Speech change	
	One sided or localized weakness	
	Seizures	
	Loss of consciousness	
	PSYCHIATRIC	
	Depression	
	Suicidal ideas	
	Substance abuse	
	Hallucinations	
	Nervous/anxious	
	Insomnia	
	Memory loss	
OTHER INFORMATION: **What method of contraception do you use?**		

Notes on positives:

Signature indicating questionnaire reviewed before being sent to SCAN: Date: