



**7. Review of systems:** Have you had any of the following over the past two weeks?  
(please circle)

**Constitutional:** fevers, chills, unexplained weight loss, fatigue

**Eyes:** visual changes, eye pain, sensitivity to light, redness, dry eye

**Ears:** hearing loss, drainage, ear pain, ringing

**Nose/Mouth/Throat:** nasal congestion, runny nose, mouth or nose sores, postnasal drip, sinus congestion, nose bleed, sore throat, difficulty swallowing, dry mouth, frequent cavities

**Cardiovascular:** chest pain, palpitations, leg edema, color changes of fingers or toes with the cold

**Respiratory:** cough, shortness of breath, wheezing, pain with deep breath

**Gastrointestinal:** diarrhea, constipation, blood in stools, abdominal pain, vomiting, heartburn

**Genitourinary:** urinary frequency, blood in urine, incontinence, pain with urinating, genital sores

**Musculoskeletal:** joint pain, joint swelling, joint stiffness, muscle pain, muscle stiffness

**Skin:** rash, lesions, skin tightening

**Neurological:** headaches, dizziness, numbness, tingling, confusion, trouble speaking, unsteady walking, muscle weakness

**Psychiatric:** anxiety, depression

**Hematologic/Lymphatic:** easy bruising, easy bleeding, swollen glands, low white blood cells, low

**Allergic/Immunologic:** itching, sneezing, watery eyes, clear rhinorrhea, recurrent infections

**Endocrine:** very thirsty, urinating often, cold/heat intolerance

Patient Signature: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_

Provider Signature: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_

Alaska Internal Medicine and Pediatrics Patient name: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_