Nephrology Associates of Dayton
Review of Systems

Name: _____
Date: _____
D.O.B. _____

		GENERAL	
YES	NO	Weight Change	
YES	NO	Appetite Change	
YES	NO	Fever	
YES	NO	Chills	
YES	NO	Night Sweats	
YES	NO	Fatigue	
		SKIN	
YES	NO	Rash / Sores	
YES	NO	Itching	
YES	NO	Yellow Jaundice	
YES	NO	Change in Hair / Nails	
		EYES	
YES	NO	Blurred Vision	
YES	NO	Double Vision	
YES	NO	Light Sensitivity	
YES	NO	Blindness	
YES	NO	Glasses	
		EARS	
YES	NO	Ear Infection	
YES	NO	Ringing in Ears	
YES	NO	Hearing Loss	
		NOSE	
YES	NO	Sinus	
YES	NO	Nosebleeds	
YES	NO	Hayfever / Allergies	
		MOUTH	
YES	NO	Bleeding Gums	
YES	NO	Frequent Sore Throats	
YES	NO	Trouble Swallowing	
YES	NO	Hoarseness	
		NECK	
YES	NO	Stiffness	
YES	NO	Pain	
YES	NO	Lumps	
		RESPITORY	
YES	NO	Wheezing	
YES	NO	Chronic Cough / Sputum	
YES	NO	Coughing Up Blood	

Please continue on other side.

CARDIOVASCULAR

YES	NO	Heart Murmur	
YES	NO	Shortness of Breath	
YES	NO	Lying Flat in Bed	
YES	NO	At Rest in a Chair	
YES	NO	With Activity	
YES	NO	Smothering When Asleep	
YES	NO	Chest Pain / Heart Attack	
YES	NO	Palpitations / Skipped Beat	
YES	NO	Leg Pain When Walking	
YES	NO	Leg / Abdominal Swelling	

GASTROINTESTINAL

YES	NO	Nausea / Vomiting	
YES	NO	Diarrhea	
YES	NO	Constipation	
YES	NO	Vomit Blood	
YES	NO	Blood in Stool	
YES	NO	Abdominal Pain	

GENITOURINARY

YES	NO	Pain / Burning with Urination	
YES	NO	Increased Urgency	
YES	NO	Urination at Night	
YES	NO	Problems Initiating Stream	
YES	NO	Problems Stopping Stream	
YES	NO	Urgency	
YES	NO	Incontinence	
YES	NO	Blood in Urine	
YES	NO	Foamy Urine	

MUSCULOSKELETAL

YES	NO	Muscle Pain	
YES	NO	Joint Pain / Arthritis	

ENDOCRINE

YES	NO	Increased Thirst	
YES	NO	Increased Urination	
YES	NO	Increased Appetite	
YES	NO	Temperature Intolerance	

NEUROPSYCHIATRIC

YES	NO	Seizures	
YES	NO	Paralysis	
YES	NO	Numbness / Tingling	
YES	NO	Depression / Anxiety	

HEMATOLOGIC

YES	NO	Low Blood Count	
YES	NO	Easy Bruising	
YES	NO	Excessive Bleeding	
YES	NO	Blood Transfustions	

Reviewed with Patient

Physician Signature:_____ **Date:** _____