Diabetes and Thyroid Center of Fort Worth, PLLC

REVIEW OF SYSTEMS

Completed by: [Staff] [Patient] [Family Member _____] on: ___/___/_____

Name:_____ [Male] [Female] Age: _____ DOB: _____

CIRCLE ALL THAT APPLY

Constitutional Symptoms *Have you noticed recently?*		**Skin** *Do you have?*	
Change in appetite	Fatigue	Sores that don't heal	Purple stretch marks
Change in Weight	Poor concentration	Severe dry skin	New facial hair
Weakness			
Ears-Nose-Mouth-Throat *Have you recently had?*		**Eyes/Head** *Have you recently had?*	
Sinus Problems	Neck masses	Blurry vision	Severe headaches
Difficulty swallowing – pills/food/liquids	Hoarseness	Peripheral vision loss	Blackouts
Respiratory *Do you have?*		**Cardiovascular** *Do you have?*	
Shortness of breath	Wheezing	Chest pain	Rapid heart rate
Frequent coughs	Excessive snoring	Palpitations	Swollen ankles
Gastrointestinal *Do you have?*		**Endocrine** *Do you have?*	
Indigestion/Heartburn	Change in bowel habits	Lumps in your breasts	Intolerance to cold
Nausea	Diarrhea	Breast discharge	Hair loss
Vomiting	Constipation	Excessive thirst	Intolerance to heat
Abdominal pain	Black stools		
Genitourinary *Do you have?*		**Neurology** *Do you feel?*	
Frequent urination day/night	Abnormal menstrual cycles	Numbness/Tingling/Burning in hands or feet	Tremors
Decreased force/flow/dribbling Difficulty initiating urine stream	Poor erection	Tingling around lips or fingertips	Shakiness
	Poor sex drive		Dizziness
Musculoskeletal *Do you have?*		**Allergies/Immune** *Do you have?*	
Back pain	Stiffness	Seasonal Allergies	
Pain in joints	Difficulty arising from a chair/climbing stairs		
Frequent muscle spasms			
Psychology *Do you feel?*		**Hematology/Lymphatic** *Do you?*	
Anxious	Depressed	Bruise easily	Swollen glands

Do you have any other signs, symptoms, or problems other than above? NO YES Please explain below:

Reviewed last by/date: