encore
UROLOGY

Review of Systems

Date: _____

Patient Full Name: _____

Do you currently have *or* have you had any of the following symptoms?

	YES	NO
Cardiovascular		
A-FIB:	☐	☐
Angina:	☐	☐
Beats Fast:	☐	☐
Blood Clots:	☐	☐
Bruises Easily:	☐	☐
Defibulator (provide card):	☐	☐
Elevated Cholesterol:	☐	☐
Heart Attack:	☐	☐
Heart Failure:	☐	☐
High Blood Pressure:	☐	☐
Increased Bleeding:	☐	☐
Irregular Beats:	☐	☐
Murmur:	☐	☐
Pacer (provide card):	☐	☐
Sickle Cell:	☐	☐
Skipped Beats:	☐	☐
Stroke:	☐	☐
Varicose Veins:	☐	☐
Constitutional Symptoms		
Chills:	☐	☐
Cold:	☐	☐
Fever:	☐	☐
Headache:	☐	☐
Weight Loss:	☐	☐
Ear / Nose / Throat		
Ear Infection:	☐	☐
Hard of Hearing:	☐	☐
Sore Throat:	☐	☐
Sinus Problems:	☐	☐
Tinnitus:	☐	☐
Eyes		
Blurred Vision:	☐	☐
Cataracts:	☐	☐
Double Vision:	☐	☐
Macular Degeneration:	☐	☐
Pain:	☐	☐
Glaucoma:	☐	☐
Endocrine		
Cancer:	☐	☐
Diabetes:	☐	☐
Diet Controlled:	☐	☐
Insulin Controlled:	☐	☐
Thyroid Disease:	☐	☐
Gastrointestinal		
Abdominal Pain:	☐	☐
Bleeding Ulcer:	☐	☐
Cancer:	☐	☐
Gallbladder:	☐	☐
Heart Burn:	☐	☐
Hemorrhoids:	☐	☐
Hernia:	☐	☐
Indigestion:	☐	☐
Liver Disease:	☐	☐
Nausea / Vomiting:	☐	☐
Pancreatic Disease:	☐	☐
Genitourinary		
Cancer:	☐	☐
Kidney Stones:	☐	☐
Painful Urination:	☐	☐
Urgency:	☐	☐
Urinary Frequency:	☐	☐
Urinary Retention:	☐	☐
Weak Stream:	☐	☐
Hematological:		
Blood Disorder:	☐	☐
Cancer:	☐	☐
Lymphoma:	☐	☐

Do you currently have *or* have you had any of the following symptoms? (cont.)

Integumentary

	YES	NO
Boils:	☐	☐
Cancer:	☐	☐
Persistent Itch:	☐	☐
Skin Rash:	☐	☐
Squamos Cell:	☐	☐

Musculoskeletal

	YES	NO
Arthritis:	☐	☐
Bone Pain:	☐	☐
Cancer:	☐	☐
Implants:	☐	☐
Joint Pain:	☐	☐
Neck Pain:	☐	☐
Jaw Pain:	☐	☐

Neurological

	YES	NO
Anxiety:	☐	☐
Depression:	☐	☐
Dizzy Spells:	☐	☐
Migraines:	☐	☐
Numbness / Tingling:	☐	☐
Seizures:	☐	☐
Tremors:	☐	☐

Respiratory

	YES	NO
Asthma:	☐	☐
COPD:	☐	☐
Emphysema:	☐	☐
Frequent Cough:	☐	☐
Lung Cancer:	☐	☐
Nodules:	☐	☐
Shortness of Breath:	☐	☐
Sleep Apnea:	☐	☐
Tuberculosis:	☐	☐
Wheezing:	☐	☐

Pain

	YES	NO
Does your condition cause you any pain?	☐	☐

If yes, on a scale of 1–10, with 10 being the most severe, circle the number that best describes the pain:

1 2 3 4 5 6 7 8 9 10