COLORADO INSTITUTE FOR NEUROMUSCULAR AND NEUROLOGICAL DISORDERS

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Review of Systems

Please place a checkmark next to any of the following symptoms you have experienced in the last month.

General	**Respiratory System**	**Gastrointestinal**
____ Night sweats	____ Cough	____ Difficulty swallowing
____ Fevers	____ Regurgitation	____ Diarrhea
____ Rash	____ Shortness of breath	____ Vomiting
____ Bleeding disorder	____ Wheezing	____ Constipation
____ Weight changes		____ Bloody stools
Loss / Gain (circle one)	**Neurologic**	____ Heartburn
____ HIV infection of AIDS	____ Headaches	____ Ulcers
____ Psychiatric diseases	____ Head injury	
____ Fatigue	____ Numbness (or tingling)	**Cardiovascular**
	____ Seizures	____ Hypertension
Head and Neck	____ Strokes	____ Palpitations
____ Double vision	____ Balance problems	____ Chest pain
____ Blurred vision	____ Weakness	____ Swelling (legs or arms)
____ Ear pain		
____ Hearing loss	**Musculoskeletal**	**Urologic**
____ Dizziness	____ Joint pain or swelling	____ Difficulty in urination
____ Ringing in ears	____ Muscle pain	____ Frequent urination
____ Sinus problems		____ Blood in the urine
____ Snoring	**Endocrine**	____ Prostate problems
____ Excessive sleepiness	____ Diabetes	
____ Facial pain	____ Heat/cold intolerance	**Other**
____ Pain with chewing	____ Thyroid imbalance	_____
____ Lumps in the neck	____ Menstrual disorders	_____
____ Neck pain		_____

Patient name (please print) _____

Patient signature _____

Physician signature _____