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:** _____