**Review of Symptoms**

Patient Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Service\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please circle if you have difficulty with:**

 bathing, dressing/grooming, toileting, transfers, eating, n/a

**Please circle if you have difficulty:**

managing money, driving, preparing meals, managing medication, housework, n/a

**Please circle all that apply to you TODAY:**

**General** fatigue, fever, weakness, weight gain/loss, n/a

**Integumentary** rashes, ulcers, skin breakdown, n/a

**Head/Neck** headache, pain, n/a

**Eyes** blurred vision, change in vision, n/a

**ENT** drooling, hearing loss, hoarseness, difficulty swallowing, n/a

**Endocrine** diabetes, thyroid problems, n/a

**Respiratory** cough, shortness of breath, wheezing, n/a

**Cardiovascular** chest pain, palpitations, edema, n/a

**Gastrointestinal**  abdominal pain, constipation, diarrhea, nausea, vomiting, n/a

**Genitourinary** urinary incontinence, recurrent Urinary Tract Infections, n/a

**Hematologic** bleeding, bruising, n/a

**Musculoskeletal**  gait changes, falls, n/a

**Neuro** confusion, dizziness, seizures, speech difficulty, tremor, n/a

**Psych** agitation, anxiety, depression, hallucinations, irritability, n/a