**Review of Symptoms**

Patient Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please circle if you have difficulty:**

bathing, dressing/grooming, toileting, transfers, eating

**Please circle if you have difficulty:**

managing money, driving, preparing meals, managing medication, housework

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

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

**Integumentary** rashes, ulcers, skin breakdown

**Head/Neck** headache, pain

**Eyes** blurred vision, change in vision

**ENT** drooling, hearing loss, hoarseness, difficulty swallowing

**Endocrine** diabetes, thyroid problems

**Respiratory** cough, shortness of breath, wheezing

**Cardiovascular** chest pain, palpitations, edema

**Gastrointestinal**  abdominal pain, constipation, diarrhea, nausea, vomiting

**Genitourinary** urinary incontinence, recurrent UTIs

**Hematologic** bleeding, bruising

**Musculoskeletal**  gait changes, falls

**Neuro** confusion, dizziness, seizures, speech difficulty, tremor

**Psych** agitation, anxiety, depression, hallucinations, irritability