NEUROLOGY CENTER OF VIRGINIA

PATIENT NAME: ______________________

DATE OF BIRTH: ______________________

REVIEW OF SYSTEMS

Do you have any of the following complaints in the past one month?

GENERAL

Fever	Yes	No
Chills	Yes	No
General Weakness	Yes	No
Aches/Pains	Yes	No
Swollen Glands	Yes	No
Other ____________	Yes	No

EAR, NOSE & THROAT

Discharge from Ears	Yes	No
Hearing Difficulty or Deafness	Yes	No
Buzzing or Ringing in Ears	Yes	No
Nosebleeds not due to Injury	Yes	No
Sinus Trouble	Yes	No
Difficulty Swallowing	Yes	No
Mouth, Tooth or Tongue Problem	Yes	No
Persistent Hoarseness	Yes	No
Other ____________	Yes	No

HEART (CARDIOVASCULAR)

Heart Murmur	Yes	No
Abnormal EKG	Yes	No
Enlarged Heart	Yes	No
Heart Attack	Yes	No
Rheumatic Fever	Yes	No
Angina	Yes	No
High Blood Pressure	Yes	No
Fluttering of Heart	Yes	No
Chest Pain or Pressure Attacks	Yes	No
Swollen Ankles	Yes	No
Leg Cramps	Yes	No
Other ____________	Yes	No

LUNGS (PULMONARY)

Shortness of Breath	Yes	No
Exercise Intolerance	Yes	No
Frequent Coughs	Yes	No
Coughing up Blood	Yes	No
Wheezing	Yes	No
Other ____________	Yes	No

NEUROMUSCULAR

Weakness in Arm or Leg	Yes	No
Difficulty with Balance	Yes	No
Dizzy Spells	Yes	No
Fainting Spells	Yes	No
Speech Difficulty	Yes	No
Headache	Yes	No
Memory Loss	Yes	No
Other ____________	Yes	No

KIDNEY (URINARY)

Blood in Urine	Yes	No
Pain or Burning while Urinating	Yes	No
Difficulty Passing Urine	Yes	No
Difficulty Controlling Urine	Yes	No
Getting Up at Night to Urinate	Yes	No
Other ____________	Yes	No

BLOOD (HEMATOLOGIC)

Anemia	Yes	No
Easy Bruising	Yes	No
Other ____________	Yes	No

GASTROINTESTINAL

Poor Appetite	Yes	No
Indigestion or Heartburn	Yes	No
Nausea or Vomiting	Yes	No
Vomiting Blood	Yes	No
Abdominal Pain or Cramps	Yes	No
Abdominal Swelling	Yes	No
Diarrhea	Yes	No
Constipation	Yes	No
Change in Bowel Habits	Yes	No
Pass Blood from Rectum	Yes	No
Black, Tar-Like Bowel Movements	Yes	No
Other ____________	Yes	No

BONES-JOINTS (MUSCULOSKELETAL)

Painful Joints	Yes	No
Swollen Joints	Yes	No
Loss of Muscle Strength	Yes	No
Lump on Bone	Yes	No
Back Pain	Yes	No
Other ____________	Yes	No

ENDOCRINE (GLANDS)

Thirsty all the time	Yes	No
Cold most of the time	Yes	No
Too Warm most of the time	Yes	No
Unusually Tire or Sluggish	Yes	No
Unusually Jumpy or Nervous	Yes	No

EYES

Double Vision	Yes	No
Loss of Vision	Yes	No
Seeing Flashes	Yes	No
Floaters or Spots	Yes	No
Temporary Loss of Vision	Yes	No
Pain in Eyes	Yes	No
Other ____________	Yes	No

WOMEN

Breast Lump	Yes	No
Discharge from Nipple	Yes	No
Other Breast Problems	Yes	No
Vaginal Discharge	Yes	No
Vaginal Bleeding or Spotting (Not Associated with Periods)	Yes	No
Hot Flashes	Yes	No
Pain with Intercourse	Yes	No
Possibly Pregnant	Yes	No
Change in Periods	Yes	No
Pain Associated with Periods	Yes	No
Other ____________	Yes	No

MEN

Breast Lump	Yes	No
Discharge from Penis	Yes	No
Sore on Penis	Yes	No
Lump in Testicles	Yes	No
Difficulty having Erections	Yes	No
Other ____________	Yes	No

PSYCHOLOGIC

Do you find your life?			
	Generally Unsatisfactory	Yes	No
	Too Demanding	Yes	No
	Boring	Yes	No
	Satisfactory	Yes	No
	Other ____________	Yes	No
Do you?	Cry Easily	Yes	No
	Often Feel Depressed	Yes	No
	Feel Anxious or Upset	Yes	No
Have you ever?			
	Considered Suicide	Yes	No
	Attempted Suicide	Yes	No

Reviewed with Patient: ____ Date: ________________