Upstate Neurology Consultants, LLP
Review of Systems

Patient Name_____________________________**DOB**: _________________

Please fill out the following form to assist the neurologist and staff to aid in your diagnosis and treatment. **Circle any symptoms you have now or previously.**

Systemic
Fatigue
Fever
Chills
Weight change

Head
Headache
Facial Pain
Sinus pain

Eye
Flashing lights
Light sensitivity
Eye pain
Blurry vision
Double vision

ENT
Earache
Hearing loss
Ringing in ears
Nose bleeds
Nasal discharge
Throat pain

Neck
Neck pain
Neck stiffness

Cardiovascular
Chest pain
Fast heart rate
Palpitations

Pulmonary
Shortness of breath
Cough
Wheezing

GI
Loss of appetite
Trouble swallowing
Heartburn
Nausea
Vomiting
Abdominal pain

GU
Urinary frequency
Incontinence
Kidney stones

Skin
Itching
Rash

Endocrine
Excess sweating
Excess thirst
Change in libido

Musculoskeletal
Joint pains
Back pain
Muscle aches
Pain in hands and feet

Neurologic
Dizziness
Vertigo
Fainting
Weakness
Numbness
Convulsions
Confusion
Memory loss

Psychological
Anxiety
Depression
Insomnia