ELFHP **Review of Systems-Adult** Date Completed: _____

*Please complete ALL pages, as it will become part of your permanent record.* Male Female

**NAME**: _____ DOB: _____ Age: _____

Please ONLY check if answering YES to current condition.

| CONSTITUTIONAL | |
|---|---|
| chills | |
| fatigue | |
| fever | |
| weight gain | |
| weight loss | |
| other | |

| EYES | |
|---|---|
| blurred vision | |
| change in vision | |
| glasses/contacts | |
| other | |

| ENT | |
|---|---|
| hearing problems | |
| ringing in ears | |
| frequent bloody nose | |
| nasal congestion | |
| sneezing | |
| dentures | |
| difficultly swallowing | |
| hoarseness | |
| sore throat | |
| other | |

| CARDIOVASCULAR | |
|---|---|
| chest pain | |
| dizziness | |
| swelling | |
| fainting | |
| palpitations | |
| other | |

| RESPIRATORY | |
|---|---|
| cough | |
| shortness of breath | |
| coughing up blood | |
| frequent wheezing | |
| other | |

| GASTROEINTESTINAL | |
|---|---|
| abdominal pain | |
| change in appetite | |
| difficulty swallowing | |
| constipation | |
| diarrhea | |
| heartburn | |
| nausea | |
| vomiting | |
| other | |

| GENITOURINARY | |
|---|---|
| painful urination | |
| urinary frequency | |
| genital lesions | |
| blood in urine | |
| urinary urgency | |
| urinary incontinence | |
| penile discharge | |
| vaginal discharge | |
| change in urine stream | |
| other | |

| MUSCULOSKELETAL | |
|---|---|
| joint pain | |
| back pain | |
| joint swelling | |
| muscle pain | |
| neck pain | |
| other | |

| INTEGUMENTARY/ BREAST | |
|---|---|
| abnormal moles | |
| hair/nail changes | |
| rash | |
| breast mass/tenderness | |
| other | |

| NEUROLOGICAL | |
|---|---|
| dizziness | |
| unstable gait | |
| headaches | |
| memory loss | |
| numbness | |
| seizures | |
| weakness | |
| other | |

| HEMATOLOGIC/ LYMPHATIC | |
|---|---|
| bruising | |
| excessive bleeding | |
| history of blood transfusion | |
| swelling in lymph nodes | |
| other | |

| PSYCHIATRIC | |
|---|---|
| anxiety | |
| depression | |
| difficultly concentrating | |
| sleep disturbance | |
| suicidal thoughts | |
| other | |

ELFHP **Review of Systems-Pediatric/Adolescent** Date Completed: _____

*Please complete ALL pages, as it will become part of your permanent record.* Male Female

**NAME:** _____ DOB: _____ Age: _____

Please ONLY check if answering YES to current condition.

| CONSTITUTIONAL | |
|---|---|
| fatigue | |
| fever | |
| weight change | |
| other | |
| **EYES** | |
| drainage | |
| glasses/contacts | |
| vision problems | |
| other | |
| **ENT** | |
| ar pain | |
| hearing problems | |
| frequent bloody nose | |
| nasal congestion | |
| sneezing | |
| Speech problems | |
| difficultly swallowing | |
| hoarseness | |
| sore throat | |
| other | |
| **CARDIOVASCULAR** | |
| chest pain | |
| swelling | |
| palpitations | |
| other | |
| **RESPIRATORY** | |
| cough | |
| shortness of breath | |
| tobacco smoke exposure | |
| frequent wheezing | |
| coughing up blood | |
| other | |

| GASTROEINTESTINAL | |
|---|---|
| abdominal pain | |
| change in appetite | |
| blood in stool | |
| constipation | |
| diarrhea | |
| nausea | |
| vomiting | |
| other | |
| **GENITOURINARY** | |
| painful urination | |
| blood in urine | |
| genital irritation | |
| other | |
| **MUSCULOSKELETAL** | |
| back pain | |
| joint pain | |
| weakness | |
| unstable gait | |
| muscle pain | |
| neck pain | |
| other | |
| **INTEGUMENTARY** | |
| abnormal mole | |
| acne | |
| eczema | |
| rash | |
| skin lesions | |
| other | |

| NEUROLOGICAL | |
|---|---|
| dizziness | |
| developmental delay | |
| headaches | |
| fainting | |
| numbness | |
| seizures | |
| other | |
| **HEMATOLOGIC/ LYMPHATIC** | |
| bruising | |
| excessive bleeding | |
| swelling in lymph nodes | |
| other | |
| **PSYCHIATRIC** | |
| behavior problems | |
| depression | |
| sleep disturbance | |
| other | |