Northwest Podiatry Center, Ltd
Review of Systems
(Circle YES or NO)

Patient Name:_____ **Date:**_____

Fevers, chills, or recent weight gain or loss

Yes No

Vision changes

Yes No

Ears, nose, mouth, or throat

Yes No

Chest pain, fast heart rate

Yes No

Shortness of breath, persistent coughing

Yes No

Stomach upset, diarrhea, constipation

Yes No

Painful urination, increased or decreased frequency

Yes No

Skin rashes, lesions, or easy bruising

Yes No

Pins and needles sensation in hands or feet, tremors

Yes No

Depression, mood swings, sleep disturbance

Yes No

Swollen hands or feet, blood in urine or stool

Yes No

Frequent sneezing, watery eyes

Yes No