

Review of Systems - Male

Are you currently having any problems related to the following systems? Check Yes or No

General

- Feeling well Yes No
 Weight loss/gain Yes No
 Fatigue Yes No
 Fever Yes No

Integumentary (skin)

- New or changing moles Yes No
 Itching Yes No
 Rash Yes No

HEENT

- Eye pain Yes No
 Change in vision/vision loss Yes No
 Change in/difficulty hearing Yes No
 Ear pain Yes No
 Runny nose Yes No
 Difficulty swallowing Yes No

Respiratory

- Cough Yes No
 Snoring Yes No
 Difficulty breathing Yes No

Breast

- Breast lumps Yes No
 Breast pain Yes No
 Nipple discharge Yes No

Cardiovascular

- Chest pain Yes No
 Palpitations Yes No
 Waking at night with
 difficulty breathing Yes No
 Swelling in legs Yes No

Gastrointestinal

- Abdominal pain Yes No
 Black or bloody stool Yes No
 Constipation Yes No
 Diarrhea Yes No
 Heartburn/indigestion Yes No
 Nausea/vomiting Yes No

Genitourinary

- Difficulty starting stream Yes No
 Impotence Yes No
 Urine loss/leakage Yes No
 Awaken at night to urinate Yes No
 Difficulty emptying bladder
 completely Yes No

Musculoskeletal

- Back pain Yes No
 Joint pain Yes No
 Have you given up any
 activity due to pain? Yes No

Neurological

- Numbness/tingling Yes No
 Difficulty speaking Yes No
 Headaches Yes No

Psychological

- Difficulty with sleep Yes No
 Anxiety Yes No
 Depression Yes No

Endocrine

- Excessive thirst Yes No
 Heat/cold intolerance Yes No

Hematology

- Easy Bruising/nosebleeds Yes No

Name _____

Date _____