DALLAS RENAL GROUP
Leaders in Kidney Care

REVIEW OF SYSTEMS

PATIENT NAME:_____ **DATE:**_____
ALLERGIES:

_____

_____

Reviewof Systems: Please circle all that apply.

Constitutional: Fever Chills Weight loss/gain Night sweats Weakness Fatigue Loss of appetite Nausea

Eyes: Blurriness Pain Discharge Itchiness

Ears/Nose/Throat: Hearing loss Earache Nasal drainage Sore throat

Cardio/Peripheral Vascular: Chest pain Difficulty breathing Fatigue Palpitations Edema Claudication Numbness

Respiratory: Shortness of breath Cough Wheezing Asthma

Gastrointestinal: Abdominal pain Reflux Nausea Vomiting

Genitourinary: Incontinence Hematuria/blood in urine Dysuria Frequency Kidney stones

Musculoskeletal: Joint pain Back problems Arthritis Muscle weakness

Skin: Skin lesions Rash Itching Hives

Neurologic: Fainting Focal Weakness Numbness Seizures

Psychiatric: Psychiatric history anxiety depression memory loss

Endocrine: Diabetes Hot and cold intolerance Thyroid disease

Hematologic: Anemia Bleeding Blood clotting problems Swollen glands

Sleep: Snoring Excessive daytime sleepiness Witnessed apnea

Others: Hepatitis type _____ HIV _____ High potassium Low potassium

Cancer: _____

Past Medial History: Please circle any that apply.

High Cholesterol	Gout	Obesity	Hypertension (high blood pressure)
Dementia	Coronary artery disease		Atrial fibrillation
GI Bleeding	Congestive Heart failure		COPD
Osteoarthrosis	Stroke	Seizures	Abdominal Aortic Aneurysm
Kidney transplant	Urinary tract infections		