

DOUGLAS R. TURGEON, M.D., P.A.

REVIEW OF SYSTEMS WORKSHEET

Name: _____ D.O.B. _____
Date: _____

IN THE PAST MONTH, HAVE YOU EXPERIENCED ANY OF THE FOLLOWING? (Circle all that apply)

- | | | |
|---------------------|--------------------------|-------------------|
| night sweats | change in sleeping habit | fainting |
| muscle weakness | numbness/tingling | cough |
| change in urination | bleeding | weight loss |
| weight gain | stiffness | fever |
| shortness of breath | chills | painful urination |
| nausea | irregular heart beat | joint swelling |
| diarrhea | bruising | chest pain |
| wheezing | excessive thirst | vomiting |
| unusual stress | anxiety | |

NONE

PLEASE GIVE DETAILS OF ALL THAT YOU HAVE CIRCLED ABOVE:
