Review of Body Systems

Name ____ Date __________________

Please check all of the following that apply to you:

		Description
Recent 10+ weight change		
Frequent fatigue		
Frequent difficulty sleeping		
Depressed or discouraged		
Mental illness		
Swollen glands or lumps		
Eye problems		
Difficulty hearing		
Hoarse voice		
Mouth sores		
Dizzy spells		
Previous seizure		
Fainting		
Persistent cough		
Recently coughed up blood		
Unusual shortness of breath		
Chest pain or tightness		
Racing heartbeat		
Swelling of feet		
Poor appetite		
Trouble swallowing		
Frequent heartburn		
Change in bowel habits		
Black or bloody stools		
Abdominal pains		
Painful urination		
Recent blood in urine		
Problems with sex life		
Kidney stone		
Problem with bladder control		
Numbness or paralysis		
Change in skin moles		
Back or neck pain		
Joint pain		
Other problems		