SOUTHWEST NEUROLOGY
REVIEW OF SYSTEMS

Please indicate below with a yes or no answer

General
Tires Easily Yes No
Weight Change Yes No
Gained Lost Yes No

Eyes
Cataracts Yes No
Droopy Eyelids Yes No
Glaucoma Yes No
Macular Degeneration Yes No
Blind Spots Yes No
Blurred Vision Yes No
Double Vision Yes No
Problems reading Yes No
Flashing Wavy Lines Yes No
Partial Vision Loss Yes No
"Curtain Drawn" Yes No
Lower Half Yes No
Upper Half Yes No
Total Vision Loss Yes No
Briefly Yes No

Ears, Nose & Throat
Difficulty Yes No
Understanding Speech Yes No
Numbness of face Yes No
Slurring of speech Yes No
Face twisting/pulling Yes No
Drooling Yes No
Hearing Loss Yes No
Right Left Both Yes No
Ringing in Ears Yes No
Right Left Both Yes No
Dizziness Yes No
Nose Bleeds Yes No
Abnormal smells Yes No
Abnormal Tastes Yes No

Gum Bleeding Yes No
Swallowing problem Yes No
Hoarseness Yes No
Loss of Taste Yes No
Coughing on Food Yes No
Change of Voice Yes No

Respiratory
Cough Yes No
Short of Breath Yes No
Wheezing Yes No

Cardiac
Chest Pain Yes No
Palpitations Yes No

Gastrointestinal
Abdominal Pain Yes No
Blood in Stool Yes No
Constipation Yes No
Heartburn Yes No
Nausea Yes No
With Vomiting Yes No

Genitourinary
Blood in Urine Yes No
Bright Red Yes No
Incontinence Yes No
Frequent Urination Yes No
Urinary Infection Yes No
Recently Yes No
Continues Yes No
Kidney Stones Yes No

Female Only
Menstruating Yes No
Postmenopausal Yes No
Premenstrual Yes No
Hysterectomy Yes No

Skin, Breast,Chest
Sensitive to Sunlight Yes No
Change in Mole Yes No
Jaundice Yes No
Rash Yes No
Breast Discharge Yes No
Breast Enlargement Yes No
Breast Lump Yes No

Other functions
Problem with Urinatic Yes No
bowel movements, Yes No
or sexual difficulties
(i.e. impotence) Yes No

Endocrine
Decrease Hair Growth Yes No
Excessive Hair Grow Yes No
Loss of Hair Yes No
Deepening of Voice Yes No
Diabetes Yes No
Excessive Hunger Yes No
Excessive Thirst Yes No
Excessive Sweating Yes No
Excessive Urination Yes No
Eyes Bulging Out Yes No
Hot Flashes Yes No
Thyroid Problems Yes No

Hematology/Lymphatic
Anemia Yes No
Bleeds Easily Yes No
Bruises Easily Yes No
Swollen Nodes Yes No

Allergic/Immunologic
Hay Fever/Asthma Yes No
Immunity Probls Yes No

Symptoms related to thinking
Fainting, passing out, convulsions Yes No
Forgetful, change of mood, ability to do daily work sports or hobbies Yes No
Gets lost, difficulty following directions Yes No
Hallucinations Yes No
Mind playing tricks Yes No
Change in Personality Yes No
Compulsive Behavior Yes No
Depression Yes No
With Elations Yes No
Comes & Goes Yes No
Anxiety Yes No

Motor &Coordination
Extremity weakness Yes No
Shaking, tremors,twitch Yes No
Trouble walk with poor balance, staggering Yes No
Reeling to one side or the other Yes No
Trouble writing, bringing a cup to one's lips Yes No
Muscle Weakness Yes No

Sensory Musculoskeletal system
Degenerative Joint Dis Yes No
Back Pain Yes No
Numbness, with pins and needles Yes No
Alteration in sense of hot, cold pain, or burning Yes No
Sense of constriction in arms, leg or body Yes No
Muscle Stiffness Yes No
Muscle Pain Yes No

Physician Signature _____ **Date**_____**2011**

Walter L. Taylor, III, M.D.