



RHEUMATOLOGY REVIEW OF SYSTEMS

Check the symptoms you currently have or have had in the past year. Please check all that apply.

<u>GENERAL</u> ☐ Fever ☐ Chills ☐ Fatigue ☐ Weight Loss ☐ Weight Gain	<u>GASTROINTESTINAL</u> ☐ Heartburn ☐ Abdominal Pain ☐ Nausea ☐ Vomiting ☐ Diarrhea / Loose Stools ☐ Constipation ☐ Blood in Stool ☐ Trouble Swallowing	<u>SKIN</u> ☐ Color changes to the fingertips ☐ New or changing skin lesions ☐ Photosensitivity ☐ Rashes ☐ Edema
<u>EYE, EAR, NOSE & THROAT</u> ☐ Visual Changes ☐ Eye Pain or Redness ☐ Eye Discharge ☐ Dry eyes ☐ Dry mouth ☐ Oral Ulcers ☐ Enlarged neck glands	<u>URINARY</u> ☐ Increased urinary frequency ☐ Loss of bladder control ☐ Pain with Urination	<u>NEURO/PSYCH</u> ☐ Headaches ☐ Numbness ☐ Tingling ☐ Dizziness ☐ Fainting ☐ Seizures ☐ Anxiety ☐ Depression ☐ Sleep Problems
<u>CARDIOVASCULAR/PULMONARY</u> ☐ Chest Pain ☐ Chest Tightness ☐ Palpitations ☐ Cough ☐ Shortness of Breath ☐ Wheezing	<u>MUSCULOSKELETAL</u> ☐ Weakness ☐ Muscle Pain ☐ Neck Pain ☐ Back Pain ☐ Joint Pain ☐ Joint Swelling	<u>ENDOCRINE</u> ☐ Heat Intolerance ☐ Cold Intolerance ☐ Night-time sweating

DEPRESSION SCREEN

Over the last 2 weeks , how often have you been bothered by the following problems:	0 Not at All	1 Several Days	2 More than half the days	3 Nearly everyday
Little interest or pleasure in doing things				
Feeling down, depressed, or hopeless				