



Male Review of Systems

Name: _____ Date of Birth: _____

Please check any current symptoms you have.

General:

YES NO

- Chills
- Fever
- Weight Gain
- Weight Loss
- Headaches

HEENT:

YES NO

- Blurred Vision
- Wear Glasses/Contact Lenses
- Hearing Loss
- Ringing Ears
- Nose Bleeds
- Chronic Sinus Infections
- Bleeding Gums

Respiratory:

YES NO

- Bloody Sputum
- Chronic Cough
- Difficulty in Breathing
- Wheezing

Cardiovascular:

YES NO

- Chest Pain
- Palpitations
- Swelling of Extremities

Gastrointestinal:

YES NO

- Black Tarry Stools
- Chronic Diarrhea
- Constipation
- Heartburn
- Nausea
- Rectal Bleeding
- Vomiting
- Ulcers

Genitourinary:

YES NO

- Blood in Urine
- Difficulty with Erection
- Flank Pain
- Frequent Urinary Infections
- Penile Lesions
- Testicular Mass
- Testicular Pain

Musculoskeletal:

YES NO

- Joint Pain
- Joint Stiffness
- Muscle Cramps
- Muscle Pain



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Neurological:

YES NO

- | | | |
|--------------------------|--------------------------|-------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Dizziness |
| <input type="checkbox"/> | <input type="checkbox"/> | Numbness |
| <input type="checkbox"/> | <input type="checkbox"/> | Seizures |
| <input type="checkbox"/> | <input type="checkbox"/> | Tingling |
| <input type="checkbox"/> | <input type="checkbox"/> | Tremors |
| <input type="checkbox"/> | <input type="checkbox"/> | Weakness in Extremities |

Endocrine:

YES NO

- | | | |
|--------------------------|--------------------------|---------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Decrease Sex Drive |
| <input type="checkbox"/> | <input type="checkbox"/> | Sleep Disturbances |
| <input type="checkbox"/> | <input type="checkbox"/> | Loss of Muscle Mass |
| <input type="checkbox"/> | <input type="checkbox"/> | Fatigue |
| <input type="checkbox"/> | <input type="checkbox"/> | Excessive Urination |

Psychiatric:

YES NO

- | | | |
|--------------------------|--------------------------|-------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Anxiety |
| <input type="checkbox"/> | <input type="checkbox"/> | Depression |
| <input type="checkbox"/> | <input type="checkbox"/> | Insomnia |
| <input type="checkbox"/> | <input type="checkbox"/> | Memory Loss |

Hematology:

YES NO

- | | | |
|--------------------------|--------------------------|-------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Anemia |
| <input type="checkbox"/> | <input type="checkbox"/> | Easy Bruising |
| <input type="checkbox"/> | <input type="checkbox"/> | Enlarged Lymph Nodes |
| <input type="checkbox"/> | <input type="checkbox"/> | Excessive Bleeding |
| <input type="checkbox"/> | <input type="checkbox"/> | Immunosuppressed |
| <input type="checkbox"/> | <input type="checkbox"/> | History of Blood Transfusions |

I affirm that I have provided all information requested by the office of Michael D. Myers, MD and that all information is true and correct to the best of my knowledge.

Patient or Guardian Signature

Date/Time

Providers Signature

Date/Time