UT Erlanger Neuromuscular Medicine

Neuromuscular Clinic

Patient Questionnaire – Review of Systems

Please complete the following:

Name: _____
Last First MI

Over the past several weeks, have you experienced any of the following symptoms:

General
- ☐ Fatigue
- ☐ Fever

Ear/Nose/Throat
- ☐ Dry mouth
- ☐ Runny nose
- ☐ Vision changes
- ☐ Speech changes
- ☐ Dizziness / vertigo

Gastrointestinal
- ☐ Difficulty swallowing
- ☐ Reflux / heartburn
- ☐ Constipation
- ☐ Diarrhea

Musculoskeletal
- ☐ Muscle pain
- ☐ Joint pain
- ☐ Swelling
- ☐ Falls
- ☐ Imbalance / difficulty walking

Dermatologic
- ☐ Rash

Neurologic
- ☐ Headaches
- ☐ Memory Loss
- ☐ Difficulty with concentration
- ☐ Seizure
- ☐ Numbness / tingling
- ☐ Weakness
- ☐ Muscle twitching / cramping

Respiratory
- ☐ Shortness of breath
- ☐ Cough

Endocrine
- ☐ Weight loss
- ☐ Weight gain

Hematologic
- ☐ Easy bruising

Psychological
- ☐ Depression
- ☐ Anxiety
- ☐ Anger / irritability
- ☐ Hallucinations / delusions
- ☐ Suicidal thoughts

Cardiovascular
- ☐ Chest pain
- ☐ Palpitations
- ☐ Lower extremity swelling

Genitourinary
- ☐ Need to urinate at night
- ☐ Frequent urination
- ☐ Urinary incontinence

- ☐ Other:

_____
_____
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