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Review of Systems Scale (ROSS)

Name: _____ **Date:** _____/_____/_____

Please put an **X** on the line between the brackets that *BEST* describes the severity of each symptom as you experienced it – DURING THE PAST WEEK.

Example1: [_____X]
Example 2: [__X_____]
Example 3: [_____X_____]
Example 4: [X_____]

		None	Severe
1.	Fatigue/tiredness ……..	[_____]	
2.	Fevers …….	[_____]	
3.	Chills ……..……..	[_____]	
4.	Facial numbness ……	[_____]	
5.	Disturbed sleep ……..……	[_____]	
6.	Poor concentration …….	[_____]	
7.	Memory loss ……	[_____]	
8.	Irritability ……..	[_____]	
9.	Crying ……..	[_____]	
10.	Sadness/depression …….	[_____]	
11.	Headaches ……..	[_____]	
12.	Blurred vision ……..	[_____]	
13.	Eye pain ……..	[_____]	
14.	Ear ringing/buzzing ……	[_____]	
15.	Jaw pain ……..	[_____]	
16.	Sore throat ……..	[_____]	
17.	Swollen glands ……..	[_____]	
18.	Dizziness ……	[_____]	
19.	Lightheadedness …….	[_____]	
20.	Stiff neck ……	[_____]	
21.	Back pain ……..	[_____]	
22.	Chest pain …….	[_____]	
23.	Palpitations ……	[_____]	
24.	Nausea ……	[_____]	
25.	Diarrhea ……..	[_____]	
26.	Testicular pain/pelvic pain ….	[_____]	
27.	Tingling/numbness/burning….	[_____]	
28.	Painful joints ……	[_____]	
29.	Stiff joints ……	[_____]	
30.	Sore muscles ..……	[_____]	
31.	Night sweats ……	[_____]	
32.	Other ……	[_____]	
33.	Other ……	[_____]	