REVIEW OF SYSTEMS

PLEASE CHECK YES OR NO IF YOU HAVE ANY **CURRENT** MEDICAL PROBLEMS RELATING TO THE FOLLOWING SYSTEMS (if yes, please explain)

GENERAL	Yes	No
Weight change	☐	☐
Appetite change	☐	☐
Sleep problems	☐	☐

HEAD	Yes	No
Migraines/Headache	☐	☐
Head injury	☐	☐

EYES	Yes	No
Blurred vision	☐	☐
Double vision	☐	☐
Pain	☐	☐
Vision changes	☐	☐

ALLERGIES	Yes	No
Seasonal Allergies	☐	☐

NEUROLOGICAL	Yes	No
Tremors	☐	☐
Dizzy spells	☐	☐
Numbness/tingling	☐	☐
Weakness (hand, legs, arms)	☐	☐

ENDOCRINE	Yes	No
Excessive thirst	☐	☐
Too hot/Too cold	☐	☐

GASTROINTESTINAL	Yes	No
Chronic constipation	☐	☐
Chronic diarrhea	☐	☐
Abdominal pain	☐	☐
Nausea/vomiting	☐	☐
Indigestion/heartburn	☐	☐
Bloody stools	☐	☐
Hernia	☐	☐
Change in bowel habits	☐	☐

CARDIOVASCULAR	Yes	No
Chest pain	☐	☐
High blood pressure	☐	☐
Palpitations	☐	☐
TIA/CVA	☐	☐

INTEGUMENTARY (SKIN)	Yes	No
Skin rash	☐	☐
Boils	☐	☐
Persistent Itch	☐	☐

MUSCULOSKELETAL	Yes	No
Joint pain	☐	☐
Neck pain	☐	☐
Back pain	☐	☐
Other pain _____	☐	☐

EARS/NOSE/THROAT/MOUTH	Yes	No
Hearing loss	☐	☐
Ringing	☐	☐
Nosebleeds	☐	☐
Swallowing problems	☐	☐
Hoarseness	☐	☐
Ulcers	☐	☐

GENITOURINARY	Yes	No
Urine retention	☐	☐
Painful urination	☐	☐
Sexually transmitted disease	☐	☐
Stones	☐	☐

RESPIRATORY	Yes	No
Wheezing	☐	☐
Chronic cough	☐	☐
Shortneess of breath	☐	☐
Other _____	☐	☐

HEMATOLOGIC/LYMPHATIC	Yes	No
Swollen glands		
Blood clotting problem		
Varicose veins	☐	☐
Other _____	☐	☐

GYNECOLOGICAL	Yes	No
Menstrual problems	☐	☐
Breast problems	☐	☐
Pregnancies # _____		
Live births # _____		

Physician comments/notes

Physician Signature _____ Date _____