REVIEW OF SYSTEMS

Patient Name: ____ DOB: __________________

Check if you currently have any of the following problems:

CONSTITUTIONAL:

___ Chills

___ Fatigue

___ Fever

___ Weight Loss/Gain

___ Other: ________________________

HEENT:

___ Dental Problems

___ Hearing Loss

___ Nasal Drainage/Sinus Pressure

___ Glaucoma

___ Other: ________________________

RESPIRATORY:

___ Chronic Cough

___ Shortness of Breath

___ Wheezing

___ Asthma

___ Other: ________________________

HEMATOLOGIC/LYMPH:

___ Easy Bleeding

___ Easy Bruising

___ Other: ________________________

CARDIOVASCULAR:

___ Artificial Heart Valves

___ Chest Pain

___ History of Blood Transfer

___ Irregular/Rapid Heartbeat

___ Poor Circulation

___ Varicose Veins

___ Other: ________________________

Date of Last EKG: _________

GASTROINTESTINAL:

___ Incontinence

___ Change in Stool

___ Constipation

___ Nausea

___ Vomiting

___ Other: ________________________

GENITOURINARY:

___ Urinary Frequency

___ Urinary Incontinence

___ Urinary Retention

___ Painful Urination

___ Blood in Urine

___ Other: ________________________

IMMUNOLOGIC:

___ Seasonal Allergies

___ Food Allergies: ________________________

___ Other: ________________________

REPRODUCTIVE:

___ Vaginal Discharge

___ Irregular Menses

___ Erectile Dysfunction

___ Penile Discharge

___ Other: ________________________

INTEGUMENTARY:

___ Redness

___ Rash

___ Hives

___ Skin Lesion

___ Hair Loss

___ Other: ________________________

PSYCHIATRIC:

___ Anxiety/Depression

___ Insomnia

___ Paranoia/Schizophrenia

___ Other: ________________________

NEUROLOGIC:

___ Dizziness

___ Numbness

___ Weakness

___ Tingling

___ Gait Disturbance

___ Headaches

___ Seizures/ Date of Last: ________________________

___ Other: ________________________

METABOLIC/END):

___ Heat/Cold Intolerance

___ Diabetes

___ Excessive Thirst/Hunger

___ Lack of Thirst/Hunger

___ Other: ________________________

MUSCULOSKETAL:

___ Back Pain

___ Neck Pain

___ Joint Paint

___ Joint Swelling

___ Muscle Weakness

___ Other: ________________________

Other pertinent medical conditions:____
____
____

Printed Name: ____ Date:____________________

Signature: ____