REVIEW OF SYSTEMS

PLEASE CIRCLE BELOW IF YOU HAVE ANY OF THESE SYMPTOMS:

EYES AND VISION

Eye disease	Yes No
Blurry vision	Yes No
Glaucoma	Yes No

EAR, NOSE, THROAT

Hearing loss	Yes No
Sinus problems	Yes No
Nose bleeds	Yes No
Swollen glands in neck	Yes No

HEART & CARDIOVASCULAR

Heart trouble	Yes No
Chest Pains	Yes No
Sudden heart beat changes	Yes No
Swelling of feet, ankles, hands	Yes No

RESPIRATORY

Frequent coughing	Yes No
Spitting up blood	Yes No
Shortness of breath	Yes No
Asthma or wheezing	Yes No

GASTROINTESTINAL

Loss of appetite	Yes No
Nausea or vomiting	Yes No
Frequent diarrhea	Yes No
Constipation	Yes No
Blood in stool	Yes No
Stomach pain	Yes No

GENITOURINARY

Frequent urination	Yes No
Burning or painful urination	Yes No
Blood in urine	Yes No
Kidney stones	Yes No
Irregular periods (females)	Yes No
Vaginal discharge (females)	Yes No

MUSCULOSKELETAL

Joint pain	Yes No
Joint swelling	Yes No
Muscle pain or cramps	Yes No
Difficulty in walking	Yes No

SKIN

Rash or itching	Yes No
Change in skin color	Yes No
Change in hair or nails	Yes No
Varicose veins	Yes No

NEUROLOGICAL

Headaches	Yes No
Light headed or dizzy	Yes No
Convulsions or seizures	Yes No
Numbness or tingling	Yes No
Tremors	Yes No
Paralysis	Yes No
Stroke	Yes No
Head injury	Yes No

ENDOCRINE

Gland or hormone problem	Yes No
Thyroid disease	Yes No
Diabetes	Yes No

HEMATOLOGIC/LYMPHATIC

Slow to heal after cuts	Yes No
Easily bruise or bleed	Yes No
Anemia	Yes No
Phlebitis	Yes No
Transfusion	Yes No
Swollen lymph glands	Yes No

If yes was circle please list the estimated date and frequency of occurrence:

_____

_____

_____

Patient Signature: _____ **Physician Signature:_____**

Date: _____