Review of Systems

Do you now or have you had any problems relating to these systems?

Please circle "Y' for Yes and "N" for No

Constitutional Symptoms			**Integumentary**		
Fever	Y	N	Skin Rash	Y	N
Chills	Y	N	Boils	Y	N
Headaches	Y	N	Persistent Itch	Y	N
Other	____________________		Other	____________________	
Eyes	Y	N	**Neurological**		
Blurred Vision	Y	N	Tremors	Y	N
Double Vision	Y	N	Dizzy Spells	Y	N
Pain	Y	N	Numbness/Tingling	Y	N
Other	____________________		Other	____________________	
Ear/Nose/Throat/Mouth			**Musculoskeletal**		
Ear Infection	Y	N	Joint Pain	Y	N
Sore Throat	Y	N	Neck Pain	Y	N
Sinus Problems	Y	N	Back Pain	Y	N
Other	____________________		Other	____________________	
Cardiovascular			**Endocrine**		
Chest Pain	Y	N	Excessive Thirst	Y	N
Varicose Veins	Y	N	Too hot/cold	Y	N
High Blood Pressure	Y	N	Tired/Sluggish	Y	N
Other	____________________		Other	____________________	
Respiratory			**Psychologic**		
Wheezing	Y	N	Are you satisfied with your life?		
Frequent Cough	Y	N		Y	N
Shortness of Breath	Y	N	Do you feel severely depressed?		
Other	____________________			Y	N
			Have you ever considered suicide?		
Gastrointestinal				Y	N
Abdomen Pain	Y	N	**Hematological/Lymphatic**		
Nausea/Vomiting	Y	N	Swollen Glands	Y	N
Indigestion/Heartburn	Y	N	Blood Clotting	Y	N
Other	____________________		Other	____________________	
Genitourinary			**Allergic/Immunologic**		
Urine Retention	Y	N	Hay Fever	Y	N
Painful Urination	Y	N	Drug Allergies	Y	N
Urinary Frequency	Y	N	Other	____________________	
Other	____________________				

Physician Use Only:

Physician:____________________ Date:_________________