PATIENT NAME

Review of Systems:

Please check any of the following medical problems you have or had and explain in the space provided below.

GENERAL
__Wt. Loss
__Wt. Gain
__Fever
__Fatigue
__Headaches
__Other

EYES
__Vision Change
__Glasses/Contacts
__ Blurred Vision
__Double Vision
__Other

ENT/MOUTH
__Sinus Problems
__Nose Bleeds
__Sore Throat
__Ear Ache
__Other

CARIO VASCULAR
__Chest Pain
__Palpitations
__SOB
__Edema
__Pacemaker
__Other

RESPIRATORY
__Coughing
__Wheezing
__Asthma
__Other

GASTROINTESTINAL
__Change in BM
__Constipation
__Rectal Bleeding
__Heartburn
__Peptic Ulcers
__Other

GENITAL/URINARY
__Frequent, Painful Urination
__Bloody Urination
__Incontinence
__Kidney Stone
__Bladder/Prostate Problems
__Other

MUSCULOSKELTAL
__Joint Stiffness/Swelling
__Muscle/Joint Weakness
__Back Pain
__Neck Pain
__Other

SKIN/BREAST
__Rash, Itching
__Change in Skin Color
__Varicose Veins
__Breast pain/lump
__Other

NEUROLOGIC
__Frequent Headaches
__Lightheadedness/Dizzy
__Stroke
__Other

PSYCHIATRIC
__Memory Loss
__Confusion
__Nervousness
__Depression
__Other

ENDOCRINE
__Thyroid Disease
__Gland/Hormone Problem
__Incr. Thirst or Urination
__Diabetes
__Other

HEMO/LYMPH
__Slow Healing
__Bleeding
__Easy Bruising
__Anemia
__Phlebitis
__Other