REVIEW OF SYSTEMS: PLEASE INDICATE ANY PERSONAL HISTORY BELOW:

CONSTITUTIONAL SYMPTOMS	Y	N
Good general health lately	☐	☐
Recent weight change	☐	☐
Decreased appetite	☐	☐
Fever/night sweats	☐	☐
Fatigue/weakness	☐	☐
Headaches	☐	☐

EYES	Y	N
Eye disease or injury	☐	☐
Wear glasses/contact lenses	☐	☐
Blurred or double vision	☐	☐
Glaucoma/cataracts	☐	☐

EARS/NOSE/THROAT	Y	N
Hearing loss or ringing	☐	☐
Earaches or drainage	☐	☐
Chronic sinus problem	☐	☐
Nose bleeds	☐	☐
Mouth sores	☐	☐
Sore throat or voice change	☐	☐
Swollen glands in neck	☐	☐
Snoring	☐	☐

CARDIOVASCULAR	Y	N
Heart trouble	☐	☐
Passing out	☐	☐
Chest pain or angina pectoris	☐	☐
Irregular heartbeat	☐	☐
Shortness of breath with walking or lying flat	☐	☐
Swelling of feet, ankles or hands	☐	☐

RESPIRATORY	Y	N
Chronic or frequent coughs	☐	☐
Spitting up blood	☐	☐
Shortness of breath	☐	☐
Asthma or wheezing	☐	☐

GASTROINTESTINAL	Y	N
Swallowing problem	☐	☐
Indigestion/heartburn	☐	☐
Loss of appetite	☐	☐
Changes in bowel movements	☐	☐
Nausea or vomiting	☐	☐
Frequent diarrhea	☐	☐
Constipation	☐	☐
Blood in stool/black tarry stools	☐	☐
Abdominal pain	☐	☐
Peptic ulcer (stomach or duodenal)	☐	☐

HEMATOLOGIC/LYMPHATIC	Y	N
Bleeding or bruising tendency	☐	☐
Anemia	☐	☐
Blood clots	☐	☐
Blood transfusion	☐	☐
Enlarged glands	☐	☐

PATIENT'S NAME: ______________________________

GENITOURINARY	Y	N
Frequent urination	☐	☐
Awaken at night to urinate	☐	☐
Blood in urine	☐	☐
Change in force of stream when urinating	☐	☐
Kidney stones	☐	☐

Female - last menstrual period __________

Female - # of pregnancies __________

Female - # of miscarriages __________

Other symptoms not listed: ______________________________

____

MUSCULOSKELETAL	Y	N
Joint pain	☐	☐
Joint stiffness or swelling	☐	☐
Weakness of muscles or joints	☐	☐
Muscle pain or cramps	☐	☐
Back pain	☐	☐
Difficulty walking	☐	☐

INTEGUMENTARY	Y	N
Rash or itching	☐	☐
Change in skin lesion	☐	☐
Change in hair or nails	☐	☐
Change in skin color	☐	☐

NEUROLOGICAL	Y	N
Leg or arm weakness	☐	☐
Fainting	☐	☐
Frequent or recurring headaches	☐	☐
Light headed or dizzy	☐	☐
Convulsion or seizures	☐	☐
Numbness or tingling sensations	☐	☐
Paralysis	☐	☐
Stroke	☐	☐
Head injury	☐	☐
Speech problem	☐	☐

PSYCHIATRIC	Y	N
Memory loss or confusion	☐	☐
Nervousness / anxiety	☐	☐
Depression	☐	☐
Insomnia	☐	☐

ENDOCRINE	Y	N
Glandular or hormone problem	☐	☐
Thyroid disease	☐	☐
Diabetes (insulin or non-insulin)	☐	☐
Excessive thirst or urination	☐	☐
Heat or cold intolerance	☐	☐

ALLERGIC/IMMUNOLOGIC

History of skin reaction or other adverse reaction to:

	Y	N
Penicillin or other antibiotics	☐	☐
Novocaine or other anesthetics	☐	☐
Aspirin or other pain remedies	☐	☐
Tetanus antitoxin or other serums	☐	☐
Iodine, merthiolate or other antiseptic	☐	☐
Other drugs/medications	☐	☐

REVIEWED BY: ______________________________