

Review of Systems: Please Indicate any personal history below:

• **CONSTITUTIONAL SYMPTOMS**

| | | |
|---------------------------------|----|-----|
| Good general health lately..... | No | Yes |
| Recent weight change..... | No | Yes |
| Fever..... | No | Yes |
| Fatigue..... | No | Yes |
| Headaches..... | No | Yes |

• **EYES**

| | | |
|----------------------------------|----|-----|
| Eye disease or injury | No | Yes |
| Wear glasses/contact lenses..... | No | Yes |
| Blurred or double vision..... | No | Yes |
| Glaucoma..... | No | Yes |

• **EARS/NOSE/MOUTH/THROAT**

| | | |
|--|----|-----|
| Hearing loss or ringing..... | No | Yes |
| Earache or drainage..... | No | Yes |
| Chronic sinus problem or rhinitis..... | No | Yes |
| Nose bleeds..... | No | Yes |
| Mouth sores..... | No | Yes |
| Bleeding gums..... | No | Yes |
| Bad breath or bad taste..... | No | Yes |
| Sore throat or voice change..... | No | Yes |
| Swollen glands in neck..... | No | Yes |

• **CARDIOVASCULAR**

| | | |
|--|----|-----|
| Heart Trouble..... | No | Yes |
| Chest pain or angina pectoris | No | Yes |
| Palpitation..... | No | Yes |
| Shortness of breath with walking or lying flat.. | No | Yes |
| Swelling of feet, ankles or hands..... | No | Yes |

• **RESPIRATORY**

| | | |
|---------------------------------|----|-----|
| Chronic or frequent coughs..... | No | Yes |
| Spitting up blood..... | No | Yes |
| Shortness of breath..... | No | Yes |
| Asthma or Wheezing..... | No | Yes |

• **GASTROINTESTINAL**

| | | |
|--|----|-----|
| Loss of appetite | No | Yes |
| Change in bowel movements | No | Yes |
| Nausea or vomiting | No | Yes |
| Frequent diarrhea..... | No | Yes |
| Painful bowel movements or constipation | No | Yes |
| Rectal bleeding or blood in stool..... | No | Yes |
| Abdominal pain..... | No | Yes |
| Peptic ulcer (Stomach or duodenal) | No | Yes |

• **GENITOURINARY**

| | | |
|-----------------------------------|----|-----|
| Frequent urination | No | Yes |
| Burning or painful urination..... | No | Yes |
| Blood in urine..... | No | Yes |

• **MUSCULOSKELETAL**

| | | |
|------------------------------------|----|-----|
| Joint pain | No | Yes |
| Joint stiffness or swelling..... | No | Yes |
| Weakness of muscles or joints..... | No | Yes |
| Muscle pain or cramps | No | Yes |
| Back pain..... | No | Yes |
| Cold extremities | No | Yes |
| Difficulty in walking | No | Yes |

• **INTEGUMENTARY (Skin, breast)**

| | | |
|------------------------------|----|-----|
| Rash or itching | No | Yes |
| Change in skin color..... | No | Yes |
| Change in hair or nails..... | No | Yes |
| Varicose veins..... | No | Yes |
| Breast pain..... | No | Yes |
| Breast lump | No | Yes |
| Breast discharge | No | Yes |

• **NEUROLOGICAL**

| | | |
|---------------------------------------|----|-----|
| Frequent or recurring headaches | No | Yes |
| Light headed or dizzy..... | No | Yes |
| Convulsions or seizures..... | No | Yes |
| Numbness or tingling sensations..... | No | Yes |
| Tremors..... | No | Yes |
| Paralysis | No | Yes |
| Stroke | No | Yes |
| Head injury..... | No | Yes |

• **PSYCHIATRIC**

| | | |
|-------------------------------|----|-----|
| Memory loss or confusion..... | No | Yes |
| Nervousness | No | Yes |
| Depression..... | No | Yes |
| Insomnia..... | No | Yes |

• **ENDOCRINE**

| | | |
|--|----|-----|
| Glandular or hormone problem | No | Yes |
| Thyroid disease..... | No | Yes |
| Diabetes (insulin or non insulin - circle one) | No | Yes |
| Excessive thirst or urination..... | No | Yes |
| Heat or cold intolerance | No | Yes |
| Skin becoming drier | No | Yes |
| Change in hat or glove size | No | Yes |

• **HEMATOLOGIC/LYMPHATIC**

| | | |
|------------------------------------|----|-----|
| Slow to heal after cuts | No | Yes |
| Bleeding or bruising tendency..... | No | Yes |
| Anemia | No | Yes |
| Phlebitis..... | No | Yes |
| Past transfusion | No | Yes |
| Enlarged glands | No | Yes |

• **ALLERGIC/IMMUNOLOGIC**

| | | |
|--|----|-----|
| History of skin reaction or other adverse reaction to: | | |
| Penicillin or other antibiotics | No | Yes |
| Morphine, Demerol, or other narcotics | No | Yes |
| Novocaine or other anesthetics..... | No | Yes |
| Aspirin or other pain remedies | No | Yes |
| Tetanus antitoxin or other serums | No | Yes |
| Iodine, merthiolate or other antiseptic..... | No | Yes |
| Other drugs/medications: _____ | | |
| Known food allergies: _____ | | |
| Environmental allergies: _____ | | |

Reviewed By: _____ **Date** _____