REVIEW OF SYSTEMS

DO YOU NOW OR HAVE YOU HAD ANY PROBLEMS RELATED TO THE FOLLOWING? CIRCLE YES or NO.
Please explain any yes answers in the space provided

Constitutional Symptoms

Fever	Y	N
Chills	Y	N
Headaches	Y	N

Other____

Eyes

Blurred vision	Y	N
Double vision	Y	N
Pain	Y	N

Other______________________________ ________________

Allergic/Immunologic

Hay Fever	Y	N
Drug allergies	Y	N

Other____________________________________ ____________

Neurological

Tremors	Y	N
Dizzy spells	Y	N
Numbness/tingling	Y	N

Other____

Endocrine

Excessive thirst	Y	N
Too hot/cold	Y	N
Tired/sluggish	Y	N

Other____

Gastrointestinal

Abdominal Pain	Y	N
Nausea/vomiting	Y	N
Indigestion/Heartburn	Y	N

Other____

Cardiovascular

Chest pain	Y	N
Varicose veins	Y	N
High blood pressure	Y	N

Other____

Intregumentary

Skin rash	Y	N
Boils	Y	N
Persistent itch	Y	N

Other____

Muscularske;etal

Joint pain	Y	N
Neck Pain	Y	N
Back pain	Y	N

Other____

Ear/Nose/Throat/Mouth

Ear infection	Y	N
Sore throat	Y	N
Sinus problems	Y	N

Other____

Genitourinary

Urine retention	Y	N
Painful urination	Y	N
Urinary frequency	Y	N

Other____

Respiratory

Wheezing	Y	N
Frequent cough	Y	N
Shortness of breath	Y	N

Other____

Hematologic/Lymphatic

Swollen glands	Y	N
Blood clotting problem	Y	N

Other____

Psychologic

Are you generally satisfied with your life?	Y	N
Do you feel severly depressed	Y	N
Have you considered suicide?	Y	N

Other____

Physician use only:

Physician: ____Date:________/________/________