Review of Systems

Please check the appropriate YES or NO column related to the areas below.

	YES	NO		YES	NO
1. Constitutional			**7. Endocrine**		
Weight Change			Increased Appetite		
Fever			Excessive Thirst		
Sweats			Hair Loss		
Fatigue			**8. Genitourinary**		
2. Eyes			Frequent Urination		
Blurred Vision			Pelvic Pain		
Excessive Tearing			Blood in Urine		
Light Sensitivity			Prostate Problems		
3. Ears, Nose, Throat			**9. Skin**		
Loss of Hearing			Rash		
Dizziness			Varicose Veins		
Nosebleeds			Moles		
Gum Bleeding			Sores		
4. Respiratory			**10. Neurological**		
Cough			Memory Loss		
Shortness of Breath			Disorientation		
Wheezing			Numbness		
5. Cardiovascular			Tingling		
Chest Pain			**11. Psychiatric**		
High Blood Pressure			Stressed		
Edema			Anxiety		
Leg Pain When Walking			Sleep Disturbance		
Color Changes in Fingers/Toes			**12. Musculoskeletal**		
6. Gastrointestinal			Joint Swelling/Pain		
Diarrhea			Muscle Cramping		
Constipation			Muscle Weakness		
Blood in Stool			**13. Hematological/Lymph**		
Reflux			Easy Bruising		
Nausea			Slow Healing Cuts		

Other:____

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The information provided in this form is true and complete to the best of my knowledge.
Print Name: ________________________________ Date: ___________________
This form was reviewed by Physician: ______________ Date: ___________________