



REVIEW OF SYSTEM

Patient Name _____ Age _____ Date _____

Do you now or have you had any problems related to the following systems?

<p>CONSTITUTIONAL Weight Gain <input type="checkbox"/> Y <input type="checkbox"/> N Chills <input type="checkbox"/> Y <input type="checkbox"/> N Night Sweats <input type="checkbox"/> Y <input type="checkbox"/> N Other _____ Comments: _____</p>	<p>GENITOURINARY Change in stream <input type="checkbox"/> Y <input type="checkbox"/> N Blood in urine <input type="checkbox"/> Y <input type="checkbox"/> N Bathroom at night <input type="checkbox"/> Y <input type="checkbox"/> N Other _____ Comments: _____</p>
<p>EYES Double Vision <input type="checkbox"/> Y <input type="checkbox"/> N Glaucoma <input type="checkbox"/> Y <input type="checkbox"/> N Cataracts <input type="checkbox"/> Y <input type="checkbox"/> N Other _____ Comments: _____</p>	<p>MUSCULOSKELETAL Bone Pain <input type="checkbox"/> Y <input type="checkbox"/> N Muscle Pain <input type="checkbox"/> Y <input type="checkbox"/> N Joint Pain <input type="checkbox"/> Y <input type="checkbox"/> N Other _____ Comments: _____</p>
<p>EARS/NOSE/THROAT Hearing Changes <input type="checkbox"/> Y <input type="checkbox"/> N Sore Throat <input type="checkbox"/> Y <input type="checkbox"/> N Sinus Problems <input type="checkbox"/> Y <input type="checkbox"/> N Other _____ Comments: _____</p>	<p>INTEGUMENTARY (SKIN) Rash <input type="checkbox"/> Y <input type="checkbox"/> N Lumps or Bumps <input type="checkbox"/> Y <input type="checkbox"/> N Moles, Skin Tags <input type="checkbox"/> Y <input type="checkbox"/> N Other _____ Comments: _____</p>
<p>CARDIOVASCULAR Chest Pain <input type="checkbox"/> Y <input type="checkbox"/> N Swelling in Ankles <input type="checkbox"/> Y <input type="checkbox"/> N Irregular Heartbeats <input type="checkbox"/> Y <input type="checkbox"/> N Other _____ Comments: _____</p>	<p>NEUROLOGICAL Tremors <input type="checkbox"/> Y <input type="checkbox"/> N Dizzy spells <input type="checkbox"/> Y <input type="checkbox"/> N Numbness/Tingling <input type="checkbox"/> Y <input type="checkbox"/> N Other _____ Comments: _____</p>
<p>PSYCHOLOGIC Do you feel anxious <input type="checkbox"/> Y <input type="checkbox"/> N Depressed <input type="checkbox"/> Y <input type="checkbox"/> N Are you often unhappy <input type="checkbox"/> Y <input type="checkbox"/> N Other _____ Comments: _____</p>	<p>RESPIRATORY Wheezing <input type="checkbox"/> Y <input type="checkbox"/> N Frequent coughs <input type="checkbox"/> Y <input type="checkbox"/> N Shortness of breaths <input type="checkbox"/> Y <input type="checkbox"/> N Other _____ Comments: _____</p>
<p>ENDOCRINE Excessive thirst <input type="checkbox"/> Y <input type="checkbox"/> N Too hot/cold <input type="checkbox"/> Y <input type="checkbox"/> N Tired/sluggish <input type="checkbox"/> Y <input type="checkbox"/> N Other _____ Comments: _____</p>	<p>GASTROINTESTINAL Abdominal pain <input type="checkbox"/> Y <input type="checkbox"/> N Nausea/Vomiting <input type="checkbox"/> Y <input type="checkbox"/> N Indigestion/Heartburn <input type="checkbox"/> Y <input type="checkbox"/> N Other _____ Comments: _____</p>
<p>HEMATOLOGIC/LYMPHATIC Swollen Glands <input type="checkbox"/> Y <input type="checkbox"/> N Bruising <input type="checkbox"/> Y <input type="checkbox"/> N Lumps or Bumps <input type="checkbox"/> Y <input type="checkbox"/> N Other _____ Comments: _____</p>	<p>ALLERGIC/IMMUNOLOGIC Hay Fever <input type="checkbox"/> Y <input type="checkbox"/> N Drug allergies <input type="checkbox"/> Y <input type="checkbox"/> N Food allergies <input type="checkbox"/> Y <input type="checkbox"/> N Other _____ Comments: _____</p>
<p>Physician Comments:</p>	

Patient Signature

Physician Signature