

PATIENT NAME:	BIRTH DATE: / /	ID NO:	DATE: / /
---------------	-----------------	--------	-----------

REVIEW OF SYSTEMS

**Please check (x) if any of the following symptoms apply to you.
If none apply, please check (x) negative.**

1. CONSTITUTIONAL	<input type="checkbox"/> NEGATIVE <input type="checkbox"/> FEVER	<input type="checkbox"/> WEIGHT LOSS <input type="checkbox"/> FATIGUE	<input type="checkbox"/> WEIGHT GAIN <input type="checkbox"/> OTHER	TALLEST HEIGHT _____
2. HEAD & EYES	<input type="checkbox"/> NEGATIVE <input type="checkbox"/> HEADACHE	<input type="checkbox"/> VISION CHANGE <input type="checkbox"/> OTHER	<input type="checkbox"/> GLASSES / CONTACTS	
3. EAR, NOSE AND THROAT	<input type="checkbox"/> NEGATIVE <input type="checkbox"/> HEARING LOSS	<input type="checkbox"/> SORE THROAT <input type="checkbox"/> MOUTH SORES	<input type="checkbox"/> SINUSITIS <input type="checkbox"/> OTHER	
4. CARDIOVASCULAR	<input type="checkbox"/> NEGATIVE <input type="checkbox"/> SWELLING OF LEGS	<input type="checkbox"/> PAINFUL BREATHING <input type="checkbox"/> PALPITATION	<input type="checkbox"/> CHEST PAIN <input type="checkbox"/> OTHER	<input type="checkbox"/> DIFFICULTY BEATHING ON EXERTION
5. RESPIRATORY	<input type="checkbox"/> NEGATIVE <input type="checkbox"/> SHORTNESS OF BREATH	<input type="checkbox"/> WHEEZING	<input type="checkbox"/> SPITTING UP OF BLOOD <input type="checkbox"/> COUGH	<input type="checkbox"/> OTHER
6. GASTROINTESTINAL	<input type="checkbox"/> NEGATIVE <input type="checkbox"/> CONSTIPATION	<input type="checkbox"/> DIARRHEA <input type="checkbox"/> FLATULENCE	<input type="checkbox"/> BLOODY STOOL <input type="checkbox"/> PAIN	<input type="checkbox"/> NAUSEA / VOMITING / INDIGESTION <input type="checkbox"/> FECAL INCONTINENCE <input type="checkbox"/> OTHER
7. URINARY	<input type="checkbox"/> NEGATIVE <input type="checkbox"/> FREQUENCY	<input type="checkbox"/> BLOOD IN THE URINE <input type="checkbox"/> INCOMPLETE EMPTYING	<input type="checkbox"/> PAINFUL URINATION	<input type="checkbox"/> URGENCY <input type="checkbox"/> INCONTINENCE
8. GYNECOLOGY	<input type="checkbox"/> ABNORMAL OR PAINFUL PERIODS <input type="checkbox"/> ABNORMAL VAGINAL BLEEDING		<input type="checkbox"/> PAINFUL INTERCOURSE <input type="checkbox"/> ABNORMAL VAGINAL DISCHARGE	<input type="checkbox"/> CHRONIC PELVIC PAIN <input type="checkbox"/> PMS <input type="checkbox"/> OTHER
9. MUSCULOSKELETAL	<input type="checkbox"/> NEGATIVE <input type="checkbox"/> OTHER	<input type="checkbox"/> MUSCLE WEAKNESS	<input type="checkbox"/> MUSCLE OR JOINT PAIN	
10. SKIN	<input type="checkbox"/> NEGATIVE <input type="checkbox"/> DRY SKIN	<input type="checkbox"/> RASH <input type="checkbox"/> MOLES	<input type="checkbox"/> SORES <input type="checkbox"/> OTHER	
11. BREAST	<input type="checkbox"/> NEGATIVE <input type="checkbox"/> DISCHARGE	<input type="checkbox"/> PAIN IN BREASTS <input type="checkbox"/> MASSES	<input type="checkbox"/> OTHER	
12. NEUROLOGIC	<input type="checkbox"/> NEGATIVE <input type="checkbox"/> TROUBLE WALKING	<input type="checkbox"/> FAINTING <input type="checkbox"/> SEVERE MEMORY PROBLEMS	<input type="checkbox"/> SEIZURES	<input type="checkbox"/> NUMBNESS <input type="checkbox"/> OTHER
13. PSYCHIATRIC	<input type="checkbox"/> NEGATIVE <input type="checkbox"/> SEVERE ANXIETY	<input type="checkbox"/> DEPRESSION <input type="checkbox"/> OTHER	<input type="checkbox"/> CRYING	
14. ENDOCRINE	<input type="checkbox"/> NEGATIVE <input type="checkbox"/> HOT FLASHES	<input type="checkbox"/> DIABETES <input type="checkbox"/> HAIR LOSS	<input type="checkbox"/> HYPOTHYROID <input type="checkbox"/> HEAT/COLD INTOLERANCE	<input type="checkbox"/> HYPERTHYROID <input type="checkbox"/> OTHER
15. HEMATOLOGIC / LYMPHATIC	<input type="checkbox"/> NEGATIVE <input type="checkbox"/> BLEEDING	<input type="checkbox"/> BRUISES <input type="checkbox"/> OTHER	<input type="checkbox"/> ENLARGED LYMPH NODES (GLANDS)	
16. ALLERGIC / IMMUNOLOGIC				
MEDICATION ALLERGIES <input type="checkbox"/> YES <input type="checkbox"/> NO				
IF ANY, PLEASE LIST ALLERGY AND TYPE REACTION:				
OTHER ALLERGIES <input type="checkbox"/> YES <input type="checkbox"/> NO				
PLEASE LIST ALLERGY AND TYPE REACTION:				
FORM COMPLETED BY: <input type="checkbox"/> PATIENT <input type="checkbox"/> OFFICE NURSE <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> OTHER:				
SIGNATURE OF PATIENT:				
DATE REVIEWED BY PHYSICIAN WITH PATIENT: / /			PHYSICIAN SIGNATURE:	