



PATIENT NAME \_\_\_\_\_

**Review of Systems:** \_\_\_\_\_

Please check any of the following medical problems you have or had and explain in the space provided below.

GENERAL

- Wt. Loss
- Wt. Gain
- Fever
- Fatigue
- Headaches
- Other

EYES

- Vision Change
- Glasses/Contacts
- Blurred Vision
- Double Vision
- Other

ENT/MOUTH

- Sinus Problems
- Nose Bleeds
- Sore Throat
- Ear Ache
- Other

CARIO VASCULAR

- Chest Pain
- Palpitations
- SOB
- Edema
- Pacemaker
- Other

RESPIRATORY

- Coughing
- Wheezing
- Asthma
- Other

GASTROINTESTINAL

- Change in BM
- Constipation
- Rectal Bleeding
- Heartburn
- Peptic Ulcers
- Other

GENITAL/URINARY

- Frequent, Painful Urination
- Bloody Urination
- Incontinence
- Kidney Stone
- Bladder/Prostate Problems
- Other

MUSCULOSKELTAL

- Joint Stiffness/Swelling
- Muscle/Joint Weakness
- Back Pain
- Neck Pain
- Other

SKIN/BREAST

- Rash, Itching
- Change in Skin Color
- Varicose Veins
- Breast pain/lump
- Other

NEUROLOGIC

- Frequent Headaches
- Lightheadedness/Dizzy
- Stroke
- Other

PSYCHIATRIC

- Memory Loss
- Confusion
- Nervousness
- Depression
- Other

ENDOCRINE

- Thyroid Disease
- Gland/Hormone Problem
- Incr. Thirst or Urination
- Diabetes
- Other

HEMO/LYMPH

- Slow Healing
- Bleeding
- Easy Bruising
- Anemia
- Phlebitis
- Other