REVIEW OF SYSTEMS

Patient instructions: Please circle any condition that you are currently experiencing or have in the past year.

Please initial the bottom of this page to acknowledge you reviewed it even if nothing is circled. Thank you.

General:	Fever	Chills	Allergies
	Weight Loss	Fatigue	Changes in Daily Routine
	Weight Gain	Night Sweats	Nausea
	Poor Appetite	Forgetfulness	Excessive Thirst
	Hoarseness	Nervousness	Excessive Stress
	Cancer	HIV/AIDS	Other:
Head:	Headache	Trauma	Loss of Consciousness
	Other:		
Eyes:	Contacts	Blurry Vision	Double Vision
	Glasses	Light Sensitivity	Flashes in Front of Eyes
	Cataracts	Spots in Vision	Glaucoma
	Other:		
Ears:	Ringing in Ears	Hearing Loss	Pain
	Drainage	Frequent Infections	Other:
Nose:	Sinus Problems	Post Nasal Drip	Nose Bleeds
	Other:		
Mouth:	Gum Bleeds	Cold Sores	Jaw Pain
	Dentures	Swelling	Difficulty Swallowing
	Changing in Taste	Sore Throat	Dental Problems
Neck:	Masses	Stiffness	Swelling
	Other:		
Lungs:	Cough	Coughing up Blood	Coughing up Sputum
	Pneumonia	Wheezing	Asthma
	Emphysema	Shortness of Breath	Other: _____
Vascular:	Chest Pain	Swelling	Calf Pain
	Palpitations	Varicose Veins	Poor Circulation
	Rapid Heartbeat	Irregular Heartbeat	Pulsations in Abdomen
	Hepatitis	Stroke	Congenital Heart Defect
	Anemia	Diabetes	Heart Surgery/Pacemaker
		High/Low blood pressure	Other:
Gastro-Intestinal:	Gas/Bloating	Vomiting	Heartburn
	Diarrhea	Constipation	Black/Bloody Stool
	Difficult Digestion	Abdominal Pain	Hemorrhoids
	Bowel Changes	Rectal Bleeding	Ulcers/Colitis
	Other: _____		Patient Initial _____