Review of Systems

Name______________________________ DOB____________________ Acct#______________

Eyes

Previous Surgery	YES	NO
Contact Lenses	YES	NO
Pain	YES	NO
Double Vision	YES	NO
Glaucoma	YES	NO
Cataracts	YES	NO
Macular Degeneration	YES	NO
Dry Eyes	YES	NO
Flashes	YES	NO
Floaters	YES	NO

Ear, Nose and Throat

Hard of Hearing	YES	NO
Ringing in Ears	YES	NO
Vertigo	YES	NO

Cardiovascular

Chest Pain	YES	NO
Dizziness	YES	NO
Fainting Spells	YES	NO
Shortness of Breath	YES	NO
Irregular Heart Beat	YES	NO
Difficulty Lying Flat	YES	NO

Constitutional

Fatigue/Weakness	YES	NO
Fever	YES	NO
Weight Gain/Loss	YES	NO

Respiratory

Cough	YES	NO
Congestion	YES	NO
Wheezing	YES	NO
Asthma	YES	NO

Gastrointestinal

Heartburn	YES	NO
Nausea/Vomiting	YES	NO
Jaundice/Hepatitis	YES	NO

Genito-Urinary

Pain/Difficulty	YES	NO
Blood in Urine	YES	NO
History of Kidney Stones	YES	NO
History of STD's	YES	NO

Psychiatric

Anxiety/Depression	YES	NO
Mood Swings	YES	NO
Difficulty Sleeping	YES	NO

Endocrine

Increased Thirst	YES	NO
Increased Hunger	YES	NO
Increased Urination	YES	NO
Increased Sweating	YES	NO
Fingernail Changes	YES	NO

Blood/Lymphnodes

Easy Bruising	YES	NO
Gums Bleed Easily	YES	NO
Prolonged Bleeding	YES	NO
Heavy Aspirin Use	YES	NO

MusculoSkeletal

Stiffness	YES	NO
Arthritis	YES	NO
Joint Pain/Swelling	YES	NO

Skin

Rash/Sores	YES	NO
Lesions	YES	NO
Hives/Eczema	YES	NO

Neurological

Seizures	YES	NO
Weakness/Paralysis	YES	NO
Numbness	YES	NO
Tremors	YES	NO

Immunologic

Hives	YES	NO
Itching	YES	NO
Runny Nose	YES	NO
Sinus Pressure	YES	NO

Today's Date______________________________