

Patient Name: _____ Date: _____

PATIENT REVIEW OF SYSTEMS

Do you consider your self generally: Healthy Not Healthy Other: _____

Have you ever experienced or are you experiencing any of the following: (Check all that apply)

Eyes	<input type="checkbox"/> Blurred Vision	<input type="checkbox"/> Painful eyes	<input type="checkbox"/> Irritation from light
<input type="checkbox"/> NONE	<input type="checkbox"/> Other _____		
Ears, Nose, Mouth or Throat	<input type="checkbox"/> Pressure in ears	<input type="checkbox"/> Itching	<input type="checkbox"/> Nose blocked
	<input type="checkbox"/> Runny nose	<input type="checkbox"/> Sores in mouth	<input type="checkbox"/> Post nasal drainage
<input type="checkbox"/> NONE	<input type="checkbox"/> Teeth hurt	<input type="checkbox"/> Grinding teeth	<input type="checkbox"/> Difficulty swallowing
	<input type="checkbox"/> Painful swallowing	<input type="checkbox"/> Other _____	
Cardiovascular (Heart)	<input type="checkbox"/> Heart palpitations	<input type="checkbox"/> Pain in the chest	<input type="checkbox"/> Shortness of breath while exercising
<input type="checkbox"/> NONE	<input type="checkbox"/> Other _____		
Respiratory (lung)	<input type="checkbox"/> Cough	<input type="checkbox"/> Wheezing	<input type="checkbox"/> Shortness of breath while sitting
<input type="checkbox"/> NONE	<input type="checkbox"/> Other _____		
Gastrointestinal (Stomach)	<input type="checkbox"/> Acid reflux	<input type="checkbox"/> Constipation	<input type="checkbox"/> Diarrhea
<input type="checkbox"/> NONE	<input type="checkbox"/> Abdominal pain	<input type="checkbox"/> Other _____	
Genitourinary (Bladder)	<input type="checkbox"/> Pain when urinating	<input type="checkbox"/> Hesitation when urinating	
<input type="checkbox"/> NONE	<input type="checkbox"/> Urination at night	<input type="checkbox"/> Other _____	
Musculoskeletal	<input type="checkbox"/> Cramping	<input type="checkbox"/> Soreness	<input type="checkbox"/> Weakness
<input type="checkbox"/> NONE	<input type="checkbox"/> Other _____		
Skin	<input type="checkbox"/> Dry skin	<input type="checkbox"/> Itchy skin	<input type="checkbox"/> Lesions on skin
<input type="checkbox"/> NONE	<input type="checkbox"/> Bleeding	<input type="checkbox"/> Other _____	
Neurological (Nerves)	<input type="checkbox"/> Twitch	<input type="checkbox"/> Abnormal movements	<input type="checkbox"/> Ringing in ears
<input type="checkbox"/> NONE	<input type="checkbox"/> Dizziness / Vertigo	<input type="checkbox"/> Other _____	
Psychiatric	<input type="checkbox"/> Depression	<input type="checkbox"/> Mood swings	<input type="checkbox"/> Situational stress
<input type="checkbox"/> NONE	<input type="checkbox"/> Other _____		
Endocrine	<input type="checkbox"/> Hot flashes	<input type="checkbox"/> Hair loss / growth	<input type="checkbox"/> Heat
<input type="checkbox"/> NONE	<input type="checkbox"/> Cold	<input type="checkbox"/> Other _____	
Hematologic / Lymph nodes	<input type="checkbox"/> Bleeding easily	<input type="checkbox"/> Night sweats	<input type="checkbox"/>
<input type="checkbox"/> NONE	<input type="checkbox"/> Other _____		
Allergic / Immunologic	<input type="checkbox"/> Sneezing	<input type="checkbox"/> Skin reaction	<input type="checkbox"/> Eye irritation / itchiness
<input type="checkbox"/> NONE	<input type="checkbox"/> Other _____		

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Reviewed/Updates

____/____/____;____ ____/____/____;____ ____/____/____;____ ____/____/____;____
____/____/____;____ ____/____/____;____ ____/____/____;____ ____/____/____;____