Patient Name: **REVIEW OF SYSTEMS** Date of Birth: _____

Patient #: _____

Do you **now** or have you had any problems related to the following in the **past year**? CHECK: Yes or No

Constitutional Symptoms					
Fever	☐	YES	☐	NO	
Chills	☐		☐		
Headache	☐		☐		
Other:					
Eyes					
Blurred vision	☐	YES	☐	NO	
Double vision	☐		☐		
Pain	☐		☐		
Other:					
Allergic/Immunologic					
Hay Fever	☐	YES	☐	NO	
Drug Allergies	☐		☐		
Other:					
Neurological					
Tremors	☐	YES	☐	NO	
Dizzy Spells	☐		☐		
Numbness/Tingling	☐		☐		
Other:					
Endocrine					
Excessive Thirst	☐	YES	☐	NO	
Too Hot/Cold	☐		☐		
Tired/Sluggish	☐		☐		
Other:					
Gastrointestinal					
Abdominal Pain	☐	YES	☐	NO	
Nausea/Vomiting	☐		☐		
Indigestion/Heartburn	☐		☐		
Other:					
Cardiovascular					
Chest Pain	☐	YES	☐	NO	
Varicose Veins	☐		☐		
High Blood Pressure	☐		☐		
Other:					

Integumentary					
Skin Rash	☐	YES	☐	NO	
Boils	☐		☐		
Persistent Itch	☐		☐		
Other:					
Musculoskeletal					
Joint Pain	☐	YES	☐	NO	
Neck Pain	☐		☐		
Back Pain	☐		☐		
Other:					
Ear/Nose/Throat/Mouth					
Ear Infection	☐	YES	☐	NO	
Sore Throat	☐		☐		
Sinus Problem	☐		☐		
Other:					
Genitourinary					
Urine Retention	☐	YES	☐	NO	
Painful Urination	☐		☐		
Urinary Frequency	☐		☐		
Other:					
Respiratory					
Wheezing	☐	YES	☐	NO	
Frequent Cough	☐		☐		
Shortness of Breathe	☐		☐		
Other:					
Hematologic/Lymphatic					
Swollen Glands	☐	YES	☐	NO	
Blood Clotting Problem	☐		☐		
	☐		☐		
Other:					
Psychological					
Do you feel anxious?	☐	YES	☐	NO	
Do you feel depressed?	☐		☐		
	☐		☐		
Other:					

If you answer YES to ANY of the following systems we recommend you to go to your Family/General Physician or Specialist and follow up on the issue(s).

Primary Provider:

Physician Signature: **Date:**