Review of Systems

Do you currently have any problems related to the following systems? Circle Y(ES) or N(O). Please explain any yes answers in the space provided.

GENERAL

FEVER	Y	N
CHILLS	Y	N
HEADACHE	Y	N
OTHER_____		

EYES

BLURRED VISION	Y	N
DOUBLE VISION	Y	N
PAIN	Y	N
OTHER _____		

ALLERGY/IMMUNOLOGY

HAY FEVER	Y	N
DRUG ALLERGIES	Y	N
OTHER	Y	N

NEUROLOGICAL

TREMORS	Y	N
DIZZY SPELLS	Y	N
NUMBNESS/TINGLING	Y	N
OTHER _____		

ENDOCRINE

EXCESSIVE THIRST	Y	N
TOO HOT/COLD	Y	N
TIREDNESS	Y	N
OTHER _____		

GASTROINTESTINAL

ABDOMINAL PAIN	Y	N
NAUSEA/VOMITING	Y	N
INDIGESTION	Y	N
OTHER _____		

CARDIOVASCULAR

CHEST PAIN	Y	N
PALPITATIONS	Y	N
HIGH BLOOD PRESSURE	Y	N
OTHER _____		

SKIN

SKIN RASH	Y	N
PERSISTENT ITCH	Y	N
OTHER _____		

MUSCULOSKETETAL

JOINT PAIN	Y	N
NECK PAIN	Y	N
BACK PAIN	Y	N
OTHER _____		

EAR/NOSE/THROAT/MOUTH

EAR INFECTION	Y	N
SORE THROAT	Y	N
SINUS PROBLEMS	Y	N
OTHER _____		

UROLOGICAL

URINATE OFTEN	Y	N
PAINFUL URINATION	Y	N
URINATE SLOWLY	Y	N
URINATE AT NIGHT	Y	N
URINARY LEAKAGE	Y	N
INCOMPLETE EMPTYING	Y	N
OTHER _____		

RESPIRATORY

WHEEZING	Y	N
FREQUENT COUGH	Y	N
SHORT OF BREATH	Y	N
OTHER _____		

HEMATOLOGIC/LYMPHATIC

SWOLLEN GLANDS	Y	N
BLEEDING PROBLEM	Y	N
OTHER _____		

PSYCHOLOGICAL

DEPRESSION	Y	N
OTHER _____		

Patient comments on any of the above: _____

_____

_____

PHYSICIAN USE ONLY: (Notes)

Physician: _____ **Date:** _____