

REVIEW OF SYSTEMS

DO YOU HAVE ANY OF THE FOLLOWING TODAY? CIRCLE YES OR NO. THE DOCTOR
REVIEW OF CLINICAL SYSTEMS WILL DISCUSS THIS WITH YOU.

NAME: _____

CONSTITUTIONAL SYMPTOMS

FEVER YES NO
CHILLS YES NO
WEIGHT LOSS YES NO
OTHER: _____

MUSCULOSKELETAL

JOINT PAIN YES NO
NECK PAIN YES NO
BACK PAIN YES NO
OTHER: _____

EYES

BLURRED VISION YES NO
DOUBLE VISION YES NO
PAIN YES NO
OTHER: _____

NEUROLOGICAL

TREMORS YES NO
DIZZY SPELLS YES NO
NUMBNESS/TINGLING YES NO
OTHER: _____

EARS/NOSE THROAT/MOUTH

EAR INFECTION YES NO
SORE THROAT YES NO
SINUS PROBLEMS YES NO
OTHER: _____

PSYCHOLOGICAL

DEPRESSED YES NO
ANXIOUS YES NO
OTHER: _____

CARDIOVASCULAR

CHEST PAIN YES NO
PALPITATIONS YES NO
OTHER: _____

HEMATOLOGIC/LYMPHATIC

LYMPH NODE PAIN/SWELLING YES NO
BLOOD CLOTTING PROBLEM YES NO
OTHER: _____

RESPIRATORY

WHEEZING YES NO
COUGH YES NO
SHORTNESS OF BREATH YES NO
OTHER: _____

ENDOCRINE

HEAT/COLD INTOLERANCE YES NO
EXCESSIVE THIRST YES NO
TIRED/SLUGGISH YES NO
OTHER: _____

GASTROINTESTINAL

ABDOMINAL PAIN YES NO
BLOODY OR DARK TARRY STOOL YES NO
DIARRHEA YES NO
CONSTIPATION YES NO
OTHER: _____

INTEGUMENT/SKIN

RASH YES NO
PERSISTENT ITCH YES NO
BOILS YES NO
EXCESSIVE SCARRING YES NO
OTHER: _____

GENITOURINARY

DISCHARGE YES NO
PAIN IN URINATION YES NO
FREQUENCY YES NO
OTHER: _____

ALLERGY/IMMUNE SYSTEM

FOOD ALLERGY YES NO
HAY FEVER YES NO
HIV YES NO
OTHER: _____

SIGNATURE: _____

DATE: _____