

Name: _____ Date: _____

REVIEW OF SYSTEMS: If you are currently having any problems in the following areas, circle and explain (if necessary).

SKIN: itching, rash, infection, ulcer, tumors (growths), other Explain:	<input type="checkbox"/> none
LYMPH NODES: swelling, tenderness, other. Explain:	<input type="checkbox"/> none
BONES, JOINTS, MUSCLES: muscle pain/cramps, joint pain/swelling, other. Explain:	<input type="checkbox"/> none
ENDOCRINE: fatigue, confusion, fainting, nervousness, hot/cold intolerance, hair loss, excessive hair growth, other Explain:	<input type="checkbox"/> none
ALLERGY/IMMUNOLOGY: recurrent infections, hayfever, hives, food allergy, drug sensitivity/allergy, other. Explain:	<input type="checkbox"/> none
HEAD: headaches, dizziness, vertigo, other. Explain:	<input type="checkbox"/> none
EARS: hearing loss, ringing, infections, other. NOSE: bleeding, loss of smell, congestion, other. THROAT: dry mouth, loss of taste, difficulty swallowing, hoarseness, other. Explain:	<input type="checkbox"/> none <input type="checkbox"/> none <input type="checkbox"/> none
NECK: pain swelling stiffness, other. Explain:	<input type="checkbox"/> none
BREASTS: tenderness, swelling, lumps, discharge, other. Explain:	<input type="checkbox"/> none
BLOOD: fever/chills, easy bruisability, prolonged bleeding, skin hemorrhages significant blood loss, other. Explain:	<input type="checkbox"/> none
RESPIRATORY: wheezing cough (productive/blood), difficulty breathing, other. Explain:	<input type="checkbox"/> none
CARDIOVASCULAR (HEART/BLOOD VESSELS): chest pain, cold hands/feet, swelling of extremities, shortness of breath, exercise intolerance, other. Explain:	<input type="checkbox"/> none
GASTROINTESTINAL (stomach/intestines): nausea, vomiting, change in bowel habits, constipation, diarrhea, bleeding, pain/cramps, other. Explain:	<input type="checkbox"/> none
GENITOURINARY (genitals/kidneys/bladder): frequency, burning, hesitancy, pain or bleeding on urination, stones, infections, incontinence, impotence, other. Explain:	<input type="checkbox"/> none
NERVOUS SYSTEM: weakness in arms/legs, numbness/tingling, loss of consciousness, falls, difficulty walking, seizures, tremors, neuralgia, other. Explain:	<input type="checkbox"/> none
PSYCHIATRIC: disorientation, mood swings, anxiety, depression, hallucinations, other. Explain:	<input type="checkbox"/> none

This form completed by: _____

To be completed by physician: _____ History reviewed: _____ Date: _____