

## Review of Systems

Please check if you have/had problems related to the area indicated.

	YES	NO		YES	NO
<b>1.CONSTITUTIONAL</b>			<b>7.ENDOCRINE SYSTEM</b>		
Weight change			Diabetes		
Fevers			Thyroid problem		
Sweats			Hormone treatment		
Fatigue			Anabolic steroids		
<b>2.EYES</b>			<b>8.BREAST/GENTIALS</b>		
Glaucoma			Menopause		
Cataracts			Masses		
Vision surgery			Genital infections		
<b>3.EARS,NOSE,THROAT</b>			<b>9.URINARY SYSTEM</b>		
Loss of hearing			Urinary tract/bladder infections		
Dizziness			Kidney stones		
Nose bleeding			Incontinence		
Gum bleeding			Trouble urinating		
<b>4.RESPIRATORY</b>			Prostate problems		
Chronic cough			<b>10.SKIN</b>		
Bronchitis			Cancers		
Shortness of breath			Rashes		
Asthma			<b>11.NEUROLOGIC</b>		
Pneumonia			Stroke		
Sinus problems			Seizures		
<b>5.CARDIOVASCULAR</b>			Head Injury		
Heart attack			Nerve damage		
Chest pain/angina			Headaches		
Heart murmur			Migraines		
Anemia			<b>12.PSYCHIATRIC</b>		
Transfusions			Depression		
Phlebitis or blood clots			Anxiety		
Rheumatic fever			Alcohol/Drug abuse		
Claudication			Other_____		
<b>6.GASTROINTESINAL</b>			<b>13.MUSCULOSKELETAL</b>		
Reflux/heartburn			Arthritis		
Hepatitis			Rheumatoid arthritis		
Blood in stools			Gout		
Diarrhea/constipation			<b>14.OTHER</b>		
Hernia/repair			Anemia		
Gall bladder disease			HIV		

The information provided in this form is true and complete to the best of my knowledge.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_