

**Review of Systems:**

Check below if you are experiencing any of the following conditions?

**CONSTITUTIONAL**

- \_\_\_ Nausea/Vomiting \_\_\_\_\_
- \_\_\_ Fever/Chills \_\_\_\_\_
- \_\_\_ Recent weight change \_\_\_\_\_

**EYES**

- \_\_\_ Eye disease or injury \_\_\_\_\_
- \_\_\_ Wear glasses/contacts \_\_\_\_\_
- \_\_\_ Blurred or double vision \_\_\_\_\_

**EARS/NOSE/MOUTH/THROAT**

- \_\_\_ Hearing loss \_\_\_\_\_
- \_\_\_ Nose bleeds \_\_\_\_\_
- \_\_\_ Sore throat \_\_\_\_\_
- \_\_\_ Sinus problems \_\_\_\_\_
- \_\_\_ Difficulty swallowing \_\_\_\_\_

**CARDIOVASCULAR**

- \_\_\_ Chest pain \_\_\_\_\_
- \_\_\_ Palpitations \_\_\_\_\_
- \_\_\_ Heart disease \_\_\_\_\_
- \_\_\_ Murmur \_\_\_\_\_
- \_\_\_ Arrhythmia \_\_\_\_\_
- \_\_\_ Leg pain when walking \_\_\_\_\_
- \_\_\_ Varicosities \_\_\_\_\_
- \_\_\_ Blood clot \_\_\_\_\_
- \_\_\_ Claudication \_\_\_\_\_

**RESPIRATORY**

- \_\_\_ Difficulty breathing \_\_\_\_\_
- \_\_\_ Shortness of breath \_\_\_\_\_
- \_\_\_ Lung disease \_\_\_\_\_

**INTEGUMENTARY**

- \_\_\_ Edema or swelling \_\_\_\_\_
- \_\_\_ Rash \_\_\_\_\_
- \_\_\_ Itching \_\_\_\_\_

**HEMATOLOGICAL**

- \_\_\_ Phlebitis \_\_\_\_\_

**ENDOCRINE**

- \_\_\_ Hormonal problem \_\_\_\_\_
- \_\_\_ Excessive thirst/urination \_\_\_\_\_
- \_\_\_ Heat or cold intolerance \_\_\_\_\_
- \_\_\_ Dry skin \_\_\_\_\_
- \_\_\_ Change in hat or glove size \_\_\_\_\_

**GASTROINTESTINAL**

- \_\_\_ GI upset \_\_\_\_\_
- \_\_\_ GI or rectal bleeding \_\_\_\_\_
- \_\_\_ Abdominal pain \_\_\_\_\_

**GENITOURINARY**

- \_\_\_ Frequent urination \_\_\_\_\_
- \_\_\_ Burning or painful urination \_\_\_\_\_
- \_\_\_ Kidney stones \_\_\_\_\_
- \_\_\_ Female # of pregnancies \_\_\_\_\_
- \_\_\_ Female # of miscarriages \_\_\_\_\_

**MUSCULOSKETAL**

- \_\_\_ Joint pain \_\_\_\_\_
- \_\_\_ Stiffness or swelling \_\_\_\_\_
- \_\_\_ Low back pain \_\_\_\_\_
- \_\_\_ Muscle weakness \_\_\_\_\_
- \_\_\_ Muscle pain \_\_\_\_\_
- \_\_\_ Muscle cramping \_\_\_\_\_

**NEUROLOGICAL**

- \_\_\_ Headache \_\_\_\_\_
- \_\_\_ Seizures \_\_\_\_\_
- \_\_\_ Numbness \_\_\_\_\_
- \_\_\_ Tingling \_\_\_\_\_
- \_\_\_ Burning \_\_\_\_\_

**PSYCHIATRIC**

- \_\_\_ Anxiety \_\_\_\_\_
- \_\_\_ Depression \_\_\_\_\_
- \_\_\_ Nervousness \_\_\_\_\_

To the best of my knowledge, I have answered the questions on this form as accurately as possible. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor and the staff of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

\_\_\_\_\_  
Print name of patient, parent or Guardian    Signature of patient, parent or Guardian    Date