REVIEW OF SYSTEMS

NAME ____________________ DOB ______________________________ DATE ___________________________________

Review of Systems. **Please indicate any personal history below. (Please check all that apply.)**

Musculoskeletal
- ☐ Joint Pain
- ☐ Joint Stiffness or Swelling
- ☐ Weakness of Muscles or Joints
- ☐ Muscle Pain or Cramps
- ☐ Cold Extremities
- ☐ Difficulty in walking
- ☐ None

Constitutional Symptoms
- ☐ Bad general health lately
- ☐ Recent Weight Change
- ☐ Fever
- ☐ Fatigue
- ☐ Headaches
- ☐ None

Ears/Nose/Mouth/Throat
- ☐ Hearing Loss or Ringing
- ☐ Earaches or Drainage
- ☐ Chronic Sinus Problems
- ☐ Nose Bleeds
- ☐ Bleeding Gums
- ☐ Sore Throat or Voice Change
- ☐ Swollen glands in neck
- ☐ None

Cardiovascular
- ☐ Heart Trouble
- ☐ Chest Pain or Angina Pectoris
- ☐ Palpitation
- ☐ Shortness of breath while walking
- ☐ Swelling of Feet, Ankles or Hands
- ☐ None

Genitourinary
- ☐ Frequent Urination
- ☐ Burning or Painful Urination
- ☐ Blood in urine
- ☐ Incontinence or Dribbling
- ☐ None

Integumentary (skin)
- ☐ Rash or Itching
- ☐ Changes in skin color
- ☐ Varicose Veins
- ☐ None

Neurological
- ☐ Light Headed or Dizzy
- ☐ Numbness or Tingling Sensations
- ☐ Tremors
- ☐ Paralysis
- ☐ None

Endocrine
- ☐ Excessive Thirst or Urination
- ☐ Heat or Cold Intolerance
- ☐ Skin Becoming Dryer
- ☐ None

Hematologic/Lymphatic
- ☐ Slow to heal after cuts
- ☐ Bleeding or Bruising Tendency
- ☐ Anemia
- ☐ Enlarged Glands
- ☐ None

Psychiatric
- ☐ Memory Loss or Confusion
- ☐ Nervousness
- ☐ Depression
- ☐ Insomnia
- ☐ None

Gastrointestinal
- ☐ Loss of Appetite
- ☐ Nausea or Vomiting
- ☐ Frequent Diarrhea
- ☐ Constipation
- ☐ Rectal Bleeding, Blood in Stool
- ☐ Abdominal Pain
- ☐ None

Respiratory
- ☐ Chronic or Frequent Coughs
- ☐ Spitting up blood
- ☐ Shortness of Breath
- ☐ Wheezing
- ☐ None

Eyes
- ☐ Eye Disease or Injury
- ☐ Wear Glasses/Contact Lens
- ☐ Blurred or Double Vision
- ☐ None

Allergic/Immunologic

List food/environmental allergies ☐ None

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CONSENT FOR TREATMENT: To the best of my knowledge the questions on this form have been answered accurately. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor of any changes in my medical status. I also authorize the health care staff to perform the necessary services I may need.

____ Signature of Patient or Parent of Minor

_______________________________ Date