

Name: _____

Date: _____

REVIEW OF SYSTEMS	<i>(Must circle Yes or No)</i>		If any yes answer, please explain below
General	Recent weight change	No Yes	
Skin	Skin condition / cancer	No Yes	
Head, eyes, ears, nose & throat (ENT)	Headaches	No Yes	
	Dizziness / blacking out	No Yes	
	Eye or hearing impairment	No Yes	
	Sinus or throat trouble	No Yes	
	Nosebleeds	No Yes	
Neck	Thyroid disease	No Yes	
	Enlarged glands	No Yes	
Respiratory	Asthma	No Yes	
	Difficulty breathing	No Yes	
	Pleurisy or pneumonia	No Yes	
Cardiovascular	Chest pain	No Yes	
	Shortness of breath	No Yes	
	Heart attack	No Yes	
	High blood pressure	No Yes	
	Blood clots in legs or lungs	No Yes	
	Swelling of feet or legs	No Yes	
	Poor circulation	No Yes	
	Irregular heartbeat	No Yes	
Gastrointestinal (GI)	Ulcer	No Yes	
	Gallbladder	No Yes	
	Hepatitis / liver trouble	No Yes	
	Bleeding with bowel movements	No Yes	
	Hemorrhoids	No Yes	
	Hiatal hernia / reflux	No Yes	
Genitourinary (GU)	Loss of urine / incontinence	No Yes	
	Frequent urination	No Yes	
	Burning, painful urination	No Yes	
	Blood in urine	No Yes	
	Kidney stones / kidney disease	No Yes	
Gynecological (GYN)	Bleeding or other problem	No Yes	
	Breast masses	No Yes	
Musculoskeletal	Fractures or other injuries	No Yes	
	Back or neck pain	No Yes	
Neurological	Seizures or other conditions	No Yes	
	Neuropathy	No Yes	
	Stroke	No Yes	
	Chronic pain	No Yes	
	Fibromyalgia	No Yes	
Psychological	Depression or other problems	No Yes	
Hematological	Blood disorder or cancer	No Yes	
	Excessive bleeding after surgery / dental work	No Yes	

Patient Signature: _____

Dr's Initials: _____ Date: _____

FOR OFFICE USE ONLY

HAVE THERE BEEN ANY CHANGES IN THE LIST ABOVE?

Yes No Comments: _____

Patient Signature: _____ Date: _____ Dr's .Initials: _____ Date: _____

Yes No Comments: _____

Patient Signature: _____ Date: _____ Dr's .Initials: _____ Date: _____

Yes No Comments: _____

Patient Signature: _____ Date: _____ Dr's .Initials: _____ Date: _____