

Name: _____

Date: _____

Review of Systems

Constitutional

- ___ Fevers/Chills/Sweats
- ___ Unexplained weight loss/gain
- ___ Fatigue/weakness
- ___ Excessive thirst or urination

Musculo-Skeletal

- ___ Muscle/Joint Pain

Ears/Nose/Throat

- ___ Difficulty hearing/ringing
- ___ Hay Fever/Allergies

Cardiovascular

- ___ Chest Pain/Discomfort
- ___ Leg Pain w/Exercise
- ___ Palpitations

Other(please specify)

Dental

- ___ Extractions
- ___ Crowns
- ___ Root Canal
- ___ Gum Disease
- ___ Fillings
- ___ Other

Respiratory

- ___ Cough/Wheeze
- ___ Difficulty Breathing

Gastrointestinal

- ___ Heartburn/Reflux
- ___ Nausea/Vomiting/Diarrhea
- ___ Nausea/Vomiting/Diarrhea
- ___ Abdominal Pain

Skin

- ___ Rash or Mole

Neurological

- ___ Numbness
- ___ Headaches
- ___ Dizziness
- ___ Memory Loss
- ___ Loss of Coordination

Blood/Lymphatic

- ___ Unexplained Lumps
- ___ Easy Bruising

Eyes

- ___ Change in Vision

Psychiatric

- ___ Anxiety/Stress
- ___ Problems with sleep
- ___ Depression

General Medical History: Past and Current medical problems (please include dates)

- | | | |
|---------------------------------------|-------------------------|--------------------------------|
| ___ Heart Disease: (specify)
_____ | ___ High Blood Pressure | ___ High Cholesterol |
| ___ Asthma/Lung Disease | ___ Diabetes | ___ Thyroid Problem |
| ___ Accidents | ___ Chemical Exposure | ___ Kidney Disease |
| ___ Other: (specify)
_____ | ___ Injuries | ___ Cancer: (specify)
_____ |

Family History: Please indicate the current status of your immediate family members (Mother, Father, Sibling, Grandparent, Aunt, Uncle)

- | | | |
|------------------------|--------------------------|-------------------------|
| ___ Alcoholism | ___ High Cholesterol | ___ High Blood Pressure |
| ___ Heart Disease | ___ Stroke | ___ Diabetes |
| ___ Cancer: type _____ | | |
| ___ Depression/Suicide | ___ Bleeding or Clotting | ___ Genetic Disorders |
| ___ Asthma/COPD | ___ Other | |