

REVIEW OF SYSTEMS: In the last 12 months have you experienced any of the following...

- Constitutional**
- Recent weight loss
 - Loss of appetite
 - Fatigue
 - Insomnia
 - Fever
 - Other: _____

Eyes

- Eye disease
- Glasses or contacts
- Blurred or double vision
- Vision loss
- Other: _____

Ears/Nose/Mouth/Throat

- Hearing loss
- Ringing in ears
- Sinus problems
- Nose bleeds
- Mouth sores
- Swollen glands in the neck
- Other: _____

Cardiovascular

- Arrhythmias
- Chest Pain
- Heart murmur
- Palpitations
- Blood clots
- Swelling of the feet or ankles
- Other: _____

Respiratory

- Shortness of breath
- Chronic cough
- Wheezing
- Other: _____

Hematological

- Bleeding tendency
- Anemia
- Recurrent infections
- Other: _____

Endocrine

- Excessive Thirst
- Heat or cold intolerance
- Glandular or hormone problems
- Other: _____

- Gastrointestinal**
- Nausea
 - Diarrhea
 - Constipation
 - Abdominal pain
 - Blood in stool
 - Other: _____

Genitourinary

- Frequent urination
- Urgency in urination
- Painful urination
- Incontinence
- Sexual difficulty
- Kidney stones
- Other: _____

Musculoskeletal

- Joint pain
- Joint swelling
- Weakness of muscles or joints
- Muscle pain or cramps
- Back pain
- Difficulty walking
- Other: _____

Neurologic

- Headaches
- Lightheadedness or dizziness
- Seizures
- Numbness or tingling sensation
- Tremors
- Paralysis
- Head injury
- Memory loss
- Fainting
- Poor balance
- Other: _____

Skin

- Rash, hives, or itching
- Changes in skin color
- Changes in nails or hair
- Other: _____

Psychiatric

- Nervousness / Anxiety
- Depression
- Hallucinations
- Other: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical condition.

Patient/Guardian Signature: _____ Date: _____ / Physician Signature: _____ date _____

