



PATIENT NAME: _____

REVIEW OF SYSTEMS - Please check any conditions you have or previously had.

GENERAL	EARS, NOSE, THROAT	CARDIOVASCULAR	MUSCULOSKELETAL	GASTROINTESTINAL
Chills _____	Allergy _____	High Blood Pressure____	Headaches _____	Abdominal pain _____
Dizziness _____	Facial Pain _____	Low Blood Pressure____	Neck Pain _____	Blood in Stool _____
Fainting _____	Grinding Teeth _____	Hardening of Arteries__	Back Pain _____	Nausea _____
Fatigue _____	Jaw Pain _____	Pain over heart _____	Joint Pain _____	Vomiting _____
Fever _____	Ringing Ears _____	Swelling in ankles _____	Shoulder _____	Indigestion _____
Weight Loss _____	Sore Throat _____	Varicose Veins _____	Elbow _____	Heartburn _____
Weight Gain _____	Sinus Infection _____	Blood Clots _____	Wrist _____	Hemorrhoids _____
Sweats _____	Ear Ache _____	Anemia _____	Hips _____	Constipation _____
Sleep Loss _____	Poor Hearing _____	Easy Bruising _____	Knees _____	Diarrhea _____
Anxiety _____	Mouth Sores _____	Lightheaded _____	Ankles/Feet _____	Liver Trouble _____
Depression _____	Other _____	Palpitations _____	Sciatica _____	Gassy Gut _____
Other _____		Other _____	Arthritis _____	Change in Appetite _____
			Bursitis _____	Food sensitivities _____
			Muscle Weakness _____	Other _____
			Numbness _____	
			Joint Swelling _____	

RESPIRATORY	GENITOURINARY	SKIN, HAIR	SENSORY, NERVES, BRAIN	OTHER CONDITIONS
Chest pain _____	Painful Urination _____	Eczema _____	Poor Balance _____	Thyroid issues _____
Shortness Of Breath _____	Kidney stones _____	Rash _____	Blurred Vision _____	Goiter _____
Wheezing _____	Loss of Bladder Control _____	Changes in Mole _____	Seizures _____	Diabetes _____
Chronic Cough _____	Prostate issues _____	Skin Cancer _____	Poor Coordination _____	Immune Disorders _____
Asthma _____	Other _____	Acne _____	Pins & Needles _____	Gout _____
Other _____		Psoriasis _____	Anxiety _____	Hypoglycemia _____
		Hair Loss _____	Depression _____	Swollen Glands _____
			Tremors _____	