



## REVIEW OF SYSTEMS

Do you now or have had any problems related to the following systems? Check YES or NO.

<b><u>CONTITUTIONAL SYMPTOMS</u></b>		<b><u>INTEGUMENTARY</u></b>	
Fever	<input type="checkbox"/> YES <input type="checkbox"/> NO	Skin Rash	<input type="checkbox"/> YES <input type="checkbox"/> NO
Chills	<input type="checkbox"/> YES <input type="checkbox"/> NO	Boils	<input type="checkbox"/> YES <input type="checkbox"/> NO
Headache	<input type="checkbox"/> YES <input type="checkbox"/> NO	Persistent Itch	<input type="checkbox"/> YES <input type="checkbox"/> NO
Other: _____	<input type="checkbox"/> YES <input type="checkbox"/> NO	Other: _____	<input type="checkbox"/> YES <input type="checkbox"/> NO
<b><u>EYES</u></b>		<b><u>MUSCULOSKELETAL</u></b>	
Blurred Vision	<input type="checkbox"/> YES <input type="checkbox"/> NO	Joint Pain	<input type="checkbox"/> YES <input type="checkbox"/> NO
Double Vision	<input type="checkbox"/> YES <input type="checkbox"/> NO	Neck Pain	<input type="checkbox"/> YES <input type="checkbox"/> NO
Pain	<input type="checkbox"/> YES <input type="checkbox"/> NO	Back Pain	<input type="checkbox"/> YES <input type="checkbox"/> NO
Other: _____	<input type="checkbox"/> YES <input type="checkbox"/> NO	Other: _____	<input type="checkbox"/> YES <input type="checkbox"/> NO
<b><u>ALLERGIC / IMMUNOLOGIC</u></b>		<b><u>EAR / NOSE / THROAT / MOUTH</u></b>	
Hay Fever	<input type="checkbox"/> YES <input type="checkbox"/> NO	Ear Infection	<input type="checkbox"/> YES <input type="checkbox"/> NO
Drug Allergies	<input type="checkbox"/> YES <input type="checkbox"/> NO	Sore Throat	<input type="checkbox"/> YES <input type="checkbox"/> NO
Other: _____	<input type="checkbox"/> YES <input type="checkbox"/> NO	Sinus Problem	<input type="checkbox"/> YES <input type="checkbox"/> NO
<b><u>NEUROLOGICAL</u></b>		Other: _____ <input type="checkbox"/> YES <input type="checkbox"/> NO	
Tremors	<input type="checkbox"/> YES <input type="checkbox"/> NO	<b><u>GENITOURINARY</u></b>	
Dizzy Spells	<input type="checkbox"/> YES <input type="checkbox"/> NO	Urine Retention	<input type="checkbox"/> YES <input type="checkbox"/> NO
Numbness / Tingling	<input type="checkbox"/> YES <input type="checkbox"/> NO	Painful Urination	<input type="checkbox"/> YES <input type="checkbox"/> NO
Other: _____	<input type="checkbox"/> YES <input type="checkbox"/> NO	Urinary Frequency	<input type="checkbox"/> YES <input type="checkbox"/> NO
<b><u>ENDOCRINE</u></b>		Other: _____ <input type="checkbox"/> YES <input type="checkbox"/> NO	
Excessive Thirst	<input type="checkbox"/> YES <input type="checkbox"/> NO	<b><u>RESPIRATORY</u></b>	
Too Hot / Too Cold	<input type="checkbox"/> YES <input type="checkbox"/> NO	Wheezing	<input type="checkbox"/> YES <input type="checkbox"/> NO
Tired / Sluggish	<input type="checkbox"/> YES <input type="checkbox"/> NO	Frequent Cough	<input type="checkbox"/> YES <input type="checkbox"/> NO
Other: _____	<input type="checkbox"/> YES <input type="checkbox"/> NO	Shortness of Breath	<input type="checkbox"/> YES <input type="checkbox"/> NO
<b><u>GASTROINTESTINAL</u></b>		Other: _____ <input type="checkbox"/> YES <input type="checkbox"/> NO	
Abdominal Pain	<input type="checkbox"/> YES <input type="checkbox"/> NO	<b><u>HEMATOLOGIC / LYMPHATIC</u></b>	
Nausea / Vomiting	<input type="checkbox"/> YES <input type="checkbox"/> NO	Swollen Glands	<input type="checkbox"/> YES <input type="checkbox"/> NO
Indigestion / Heartburn	<input type="checkbox"/> YES <input type="checkbox"/> NO	Blood Clotting Problem	<input type="checkbox"/> YES <input type="checkbox"/> NO
Other: _____	<input type="checkbox"/> YES <input type="checkbox"/> NO	Other: _____	<input type="checkbox"/> YES <input type="checkbox"/> NO
<b><u>CARDIOVASCULAR</u></b>		<b><u>PSYCHOLOGIC</u></b>	
Chest Pain	<input type="checkbox"/> YES <input type="checkbox"/> NO	Are you generally satisfied with your life?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Varicose Veins	<input type="checkbox"/> YES <input type="checkbox"/> NO	Do you feel severely depressed?	<input type="checkbox"/> YES <input type="checkbox"/> NO
High Blood Pressure	<input type="checkbox"/> YES <input type="checkbox"/> NO	Have you considered suicide?	<input type="checkbox"/> YES <input type="checkbox"/> NO
<b><u>LAST EYE &amp; DENTAL EXAM</u></b>		<b><u>SEXUAL HISTORY</u></b>	
Last Eye Exam – Date: _____		Are you sexually active?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Last Dental Exam – Date: _____		Change in sex drive?	<input type="checkbox"/> YES <input type="checkbox"/> NO
<b><u>PAIN</u></b>		Sexual Performance satisfactory?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Are you having Pain?	<input type="checkbox"/> YES <input type="checkbox"/> NO	Other (i.e. Sexual Trauma)	<input type="checkbox"/> YES <input type="checkbox"/> NO
Is it adequately controlled	<input type="checkbox"/> YES <input type="checkbox"/> NO		

**Physician use only: (comments / notes):**

Physician: \_\_\_\_\_

Date: \_\_\_\_\_

*(Last Revised 11/1/2008)*