

NAME:

DATE:

REVIEW OF SYSTEMS

CONSTITUTIONAL SYMPTOMS		MUSCULOSKELETAL	
Recent weight change	<input type="checkbox"/> No <input type="checkbox"/> Yes	Joint pain, stiffness or swelling	<input type="checkbox"/> No <input type="checkbox"/> Yes
Fever	<input type="checkbox"/> No <input type="checkbox"/> Yes	Muscle weakness	<input type="checkbox"/> No <input type="checkbox"/> Yes
Headaches	<input type="checkbox"/> No <input type="checkbox"/> Yes	Muscle pain or cramps	<input type="checkbox"/> No <input type="checkbox"/> Yes
		Back or neck pain	<input type="checkbox"/> No <input type="checkbox"/> Yes
EYES		Cold extremities	<input type="checkbox"/> No <input type="checkbox"/> Yes
Eye injury	<input type="checkbox"/> No <input type="checkbox"/> Yes	Difficulty walking	<input type="checkbox"/> No <input type="checkbox"/> Yes
Contact lenses	<input type="checkbox"/> No <input type="checkbox"/> Yes		
Blurred or double vision	<input type="checkbox"/> No <input type="checkbox"/> Yes	NEUROLOGICAL	
Glaucoma	<input type="checkbox"/> No <input type="checkbox"/> Yes	Recurring headaches	<input type="checkbox"/> No <input type="checkbox"/> Yes
		Dizziness	<input type="checkbox"/> No <input type="checkbox"/> Yes
EARS/NOSE/MOUTH/THROAT		Seizures	<input type="checkbox"/> No <input type="checkbox"/> Yes
Hearing loss/ringing	<input type="checkbox"/> No <input type="checkbox"/> Yes	Numbness/tingling	<input type="checkbox"/> No <input type="checkbox"/> Yes
Earaches	<input type="checkbox"/> No <input type="checkbox"/> Yes	Tremors	<input type="checkbox"/> No <input type="checkbox"/> Yes
Chronic sinus problems	<input type="checkbox"/> No <input type="checkbox"/> Yes	Paralysis	<input type="checkbox"/> No <input type="checkbox"/> Yes
Swollen glands in neck	<input type="checkbox"/> No <input type="checkbox"/> Yes	Stroke	<input type="checkbox"/> No <input type="checkbox"/> Yes
		Walking difficulty	<input type="checkbox"/> No <input type="checkbox"/> Yes
CARDIAC		Memory loss	<input type="checkbox"/> No <input type="checkbox"/> Yes
Pacemaker	<input type="checkbox"/> No <input type="checkbox"/> Yes	Insomnia	<input type="checkbox"/> No <input type="checkbox"/> Yes
Chest pain	<input type="checkbox"/> No <input type="checkbox"/> Yes		
Heart attack	<input type="checkbox"/> No <input type="checkbox"/> Yes	PSYCHIATRIC	
Swelling hands/feet	<input type="checkbox"/> No <input type="checkbox"/> Yes	Depression	<input type="checkbox"/> No <input type="checkbox"/> Yes
Cold extremities	<input type="checkbox"/> No <input type="checkbox"/> Yes	Manic-depression	<input type="checkbox"/> No <input type="checkbox"/> Yes
		Nervousness	<input type="checkbox"/> No <input type="checkbox"/> Yes
LUNGS		Confusion	<input type="checkbox"/> No <input type="checkbox"/> Yes
Frequent coughs	<input type="checkbox"/> No <input type="checkbox"/> Yes		
Short of breath	<input type="checkbox"/> No <input type="checkbox"/> Yes	ENDOCRINE	
Asthma/wheezing	<input type="checkbox"/> No <input type="checkbox"/> Yes	Thyroid disease	<input type="checkbox"/> No <input type="checkbox"/> Yes
		Diabetes	<input type="checkbox"/> No <input type="checkbox"/> Yes
GASTROINTESTINAL		High Cholesterol	<input type="checkbox"/> No <input type="checkbox"/> Yes
Loss of appetite	<input type="checkbox"/> No <input type="checkbox"/> Yes		
Nausea or vomiting	<input type="checkbox"/> No <input type="checkbox"/> Yes	HEMATOLOGY	
Blood in stool	<input type="checkbox"/> No <input type="checkbox"/> Yes	Easy bleeding/bruising	<input type="checkbox"/> No <input type="checkbox"/> Yes
Heartburn or stomach ulcers	<input type="checkbox"/> No <input type="checkbox"/> Yes	Anemia	<input type="checkbox"/> No <input type="checkbox"/> Yes
		Phlebitis/blood clot	<input type="checkbox"/> No <input type="checkbox"/> Yes
KIDNEYS		Past transfusion	<input type="checkbox"/> No <input type="checkbox"/> Yes
Frequent urination	<input type="checkbox"/> No <input type="checkbox"/> Yes		
Blood in urine	<input type="checkbox"/> No <input type="checkbox"/> Yes	ALLERGIES	
Poor bladder control	<input type="checkbox"/> No <input type="checkbox"/> Yes	Penicillin/other antibiotics	<input type="checkbox"/> No <input type="checkbox"/> Yes
Kidney stones	<input type="checkbox"/> No <input type="checkbox"/> Yes	Sulfa	<input type="checkbox"/> No <input type="checkbox"/> Yes
Male – erection trouble	<input type="checkbox"/> No <input type="checkbox"/> Yes	Morphine, Demerol, narcotics	<input type="checkbox"/> No <input type="checkbox"/> Yes
		Aspirin, anti-inflammatory	<input type="checkbox"/> No <input type="checkbox"/> Yes
SKIN		Novocain, anesthetics	<input type="checkbox"/> No <input type="checkbox"/> Yes
Rash or itching	<input type="checkbox"/> No <input type="checkbox"/> Yes	Tetanus or other serums	<input type="checkbox"/> No <input type="checkbox"/> Yes
Change in skin or hair	<input type="checkbox"/> No <input type="checkbox"/> Yes	IODINE, CONTRAST DYE	<input type="checkbox"/> No <input type="checkbox"/> Yes
Varicose veins	<input type="checkbox"/> No <input type="checkbox"/> Yes	Other _____	