Review of Systems

Have you recently had any problems related to the following systems?

General

Fever	Yes	No
Chills	Yes	No
Headache	Yes	No

Other ______________________

Head, Ears, Eyes, Nose, Throat

Blurred Vision	Yes	No
Double Vision	Yes	No
Eye Pain	Yes	No
Ear Infection	Yes	No
Sore Throat	Yes	No
Sinus Problem	Yes	No

Other ______________________

Respiratory

Wheezing	Yes	No
Frequent Cough	Yes	No
Shortness of Breath	Yes	No

Other ______________________

Cardiovascular

Chest Pain	Yes	No
Varicose Veins	Yes	No
High Blood Pressure	Yes	No

Other ______________________

Gastrointestinal

Abdominal Pain	Yes	No
Nausea/Vomiting	Yes	No
Indigestion/Heartburn	Yes	No

Other ______________________

Genitourinary

Urine Retention	Yes	No
Painful Urination	Yes	No
Urinary Frequency	Yes	No

Other ______________________

Musculoskeletal

Joint Pain	Yes	No
Neck Pain	Yes	No
Back Pain	Yes	No

Other ______________________

Neurological

Tremors	Yes	No
Dizzy Spells	Yes	No
Numbness/Tingling	Yes	No

Other ______________________

Psychologic

Are you generally satisfied with your life?	Yes	No
Do you feel severely depressed?	Yes	No
Have you considered suicide?	Yes	No

Endocrine

Excessive Thirst	Yes	No
Too Hot/Cold	Yes	No
Tired/Sluggish	Yes	No

Other ______________________

Hematologic/Lymphatic

Swollen Glands	Yes	No
Blood Clotting Problem	Yes	No

Other ______________________

Name: ______________________ Date: ______________________