

Review of Systems

Patient Name: _____

Date: _____

Have you had trouble with any of the following?

Cardiovascular:

	No <input type="checkbox"/>		
	<u>Present</u>	<u>Past</u>	<u>No</u>
Poor Circulation	0	0	0
High Blood Pressure	0	0	0
Aortic Aneurysm	0	0	0
Heart Disease	0	0	0
Vascular Disease	0	0	0
Heart Attack	0	0	0
Chest Pain	0	0	0
High Cholesterol	0	0	0
Pace Maker	0	0	0
Jaw Pain	0	0	0
Irregular Heartbeat	0	0	0
Swelling of Legs	0	0	0

Genitourinary:

	No <input type="checkbox"/>		
	<u>Present</u>	<u>Past</u>	<u>No</u>
Kidney Disease	0	0	0
Lower Side Pain	0	0	0
Burning Urination	0	0	0
Frequent Urination	0	0	0
Blood in Urine	0	0	0
Kidney Stone	0	0	0

Hematologic/Lymphatic:

	No <input type="checkbox"/>		
	<u>Present</u>	<u>Past</u>	<u>No</u>
Hepatitis	0	0	0
Blood Clots	0	0	0
Cancer	0	0	0
Easy Bruising	0	0	0
Easy Bleeding	0	0	0
Fevers/Chills/Sweats	0	0	0

Respiratory:

	No <input type="checkbox"/>		
	<u>Present</u>	<u>Past</u>	<u>No</u>
Asthma	0	0	0
Tuberculosis	0	0	0
Shortness of Breath	0	0	0
Emphysema	0	0	0
Cold/Flu	0	0	0
Cough/Wheezing	0	0	0

Ears/Nose/Throat:

	No <input type="checkbox"/>		
	<u>Present</u>	<u>Past</u>	<u>No</u>
Dizziness	0	0	0
Hearing Loss	0	0	0
Sinus Infection	0	0	0
Nosebleed	0	0	0
Sore Throat	0	0	0
Difficulty Swallowing	0	0	0
Bleeding Gums	0	0	0

Eyes:

	No <input type="checkbox"/>		
	<u>Present</u>	<u>Past</u>	<u>No</u>
Glaucoma	0	0	0
Double Vision	0	0	0
Blurred Vision	0	0	0

Integumentary:

	No <input type="checkbox"/>		
	<u>Present</u>	<u>Past</u>	<u>No</u>
Skin Lesions	0	0	0
Skin Ulcers	0	0	0
Skin Disease	0	0	0
Eczema	0	0	0
Psoriasis	0	0	0
Rashes	0	0	0

Allergic/Immunologic:

	No <input type="checkbox"/>		
	<u>Present</u>	<u>Past</u>	<u>No</u>
Hives	0	0	0
Immune Disorder	0	0	0
HIV/AIDS	0	0	0
Cortisone Use	0	0	0

Gastrointestinal:

	No <input type="checkbox"/>		
	<u>Present</u>	<u>Past</u>	<u>No</u>
Gallbladder Problems	0	0	0
Bowel Problems	0	0	0
Constipation	0	0	0
Liver Problems	0	0	0
Ulcers	0	0	0
Diarrhea	0	0	0
Nausea/Vomiting	0	0	0
Bloody Stools	0	0	0
Poor Appetite	0	0	0

Musculoskeletal:

	No <input type="checkbox"/>		
	<u>Present</u>	<u>Past</u>	<u>No</u>
Back Pain	0	0	0
Neck Pain	0	0	0
Gout	0	0	0
Arthritis	0	0	0
Joint Stiffness	0	0	0
Muscle Weakness	0	0	0
Osteoporosis	0	0	0
Broken Bones	0	0	0
Joints Replaced	0	0	0

Endocrine:

	No <input type="checkbox"/>		
	<u>Present</u>	<u>Past</u>	<u>No</u>
Thyroid Disease	0	0	0
Diabetes	0	0	0
Hair Loss	0	0	0
Menopause	0	0	0
Menstrual Problem	0	0	0

Psychiatric:

	No <input type="checkbox"/>		
	<u>Present</u>	<u>Past</u>	<u>No</u>
Depression	0	0	0
Anxiety Disorder	0	0	0
Unusual Stress	0	0	0

Constitutional:

	No <input type="checkbox"/>		
	<u>Present</u>	<u>Past</u>	<u>No</u>
Weight Loss/Gain	0	0	0
Energy Level Problem	0	0	0
Difficulty Sleeping	0	0	0

Neurological:

	No <input type="checkbox"/>		
	<u>Present</u>	<u>Past</u>	<u>No</u>
Babinski	0	0	0
Stroke	0	0	0
Seizures	0	0	0
Head Injury	0	0	0
Brain Aneurysm	0	0	0
Numbness	0	0	0
Severe Headaches	0	0	0
Pinched Nerves	0	0	0
Parkinson's Disease	0	0	0
Carpal Tunnel	0	0	0
Spinning/Balance	0	0	0