REVIEW OF SYSTEMS

Do you now or have you had any recent problems related to the following systems? Circle **Yes** or **No**.

Please explain any Yes answers in space provided.

Constitutional Symptoms

Fever	Y	N
Chills	Y	N
Headache	Y	N
Other _____		

Allergic/Immunologic

Drug allergies	Y	N
Other _____		

Eyes

Blurred vision	Y	N
Double vision	Y	N
Pain	Y	N
Other _____		

Ear/Nose/Throat/Mouth

Ear infection	Y	N
Sore throat	Y	N
Sinus problems	Y	N
Other _____		

Neurological

Tremors	Y	N
Dizzy spells	Y	N
Numbness/tingling	Y	N
Other _____		

Cardiovascular

Chest pain	Y	N
Varicose veins	Y	N
High blood pressure	Y	N
Other _____		

Respiratory

Wheezing	Y	N
Frequent cough	Y	N
Shortness of breath	Y	N
Other _____		

Gastrointestinal

Abdominal pain	Y	N
Nausea/vomiting	Y	N
Indigestion/heartburn	Y	N
Constipation	Y	N
Other_____		

Genitourinary

Urine retention (can't void)	Y	N
Urine incontinence (leakage)	Y	N
Urinary frequency	Y	N
Painful urination	Y	N
Erection difficulties	Y	N
Other _____		

Musculoskeletal

Joint pain	Y	N
Neck pain	Y	N
Back pain	Y	N
Other _____		

Integumentary

Skin rash	Y	N
Boils	Y	N
Persistent itch	Y	N
Other _____		

Endocrine

Excessive thirst	Y	N
Too hot	Y	N
Too cold	Y	N
Tired or sluggish	Y	N
Other _____		

Hematologic/Lymphatic

Swollen glands	Y	N
Blood clotting problem	Y	N
Other _____		

I have read through the full form and answered "YES to any applicable systems. All unmarked systems are "NO". Patient signature_____

Office use only

Date _____ Physician signature_____