

Name \_\_\_\_\_ DOB \_\_\_\_\_ DATE \_\_\_\_\_

**Review of Systems**

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

**CONSTITUTIONAL SYSTEMS**

Appetite Change	Y	N
Chills	Y	N
Fever	Y	N
Headache	Y	N
Weight Loss	Y	N

**GASTROINTESTINAL**

Abdominal Pain	Y	N
Black Stools	Y	N
Heartburn/Vomiting	Y	N
Constipation	Y	N

**CARDIOVASCULAR**

Chest Pain	Y	N
Irregular Pulse	Y	N
Swelling of Ankles	Y	N
Severe Headaches	Y	N
Chest Discomfort to Arm	Y	N

**ENDOCRINE**

Excessive Thirst	Y	N
Too Hot/Cold	Y	N
Tired/Sluggish	Y	N

**RESPIRATORY**

Wheezing	Y	N
Chronic Cough	Y	N
Coughing Blood/Pus	Y	N
Shortness of Breath	Y	N
Pain on Breathing	Y	N

**MUSCULOSKELETAL**

Joint Stiffness	Y	N
Joint Pain	Y	N
Joint Swelling	Y	N
Back Pain	Y	N

**SKIN**

Persistent Itching	Y	N
Unexplained Perspiration	Y	N
Rash	Y	N
Boils	Y	N

**ALLERGIC/IMMUNOLOGIC**

Hives	Y	N
Drug Allergies	Y	N
Food Allergies	Y	N
Swelling of Lips/Eyes	Y	N

**NEUROLOGICAL**

Dizziness	Y	N
Numbness	Y	N
Sciatica	Y	N
Seizures	Y	N

**HEMATOLOGICAL**

Bleeding Problems	Y	N
Bruising Easily	Y	N
Yellow Sking	Y	N
Poor Healing	Y	N
Swollen Glands	Y	N

Explain any yes answers here: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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