REVIEW OF SYSTEMS

DO YOU NOW OR HAVE YOU HAD ANY PROBLEMS IN THE PAST 2 WEEKS RELATED TO THE FOLLOWING SYTEMS? CIRCLE YES OR NO. PLEASE EXPLAIN ANY YES ANSWERS IN THE SPACE PROVIDED.

CONSTITUTIONAL SYMPTOMS

FEVER Y N
CHILLS Y N
HEADACHE Y N
OTHER _____

EYES

BLURRED VISION Y N
DOUBLE VISION Y N
PAIN Y N
OTHER _____

ALLERGIC/IMMUNOLOGIC

HAY FEVER Y N
DRUG ALLERGIES Y N
OTHER _____

NEUROLOGICAL

TREMORS Y N
DIZZY SPELLS Y N
NUMBNESS/TINGLING Y N
OTHER _____

ENDOCRINE

EXCESSIVE THIRST Y N
TOO HOT/COLD Y N
TIRED/SLUGGISH Y N
OTHER _____

GASTROINTESTINAL

ABDOMINAL PAIN Y N
NAUSEA/VOMITING Y N
INDIGESTION/HEARTBURN Y N
OTHER _____

CARDIOVASCULAR

CHEST PAIN Y N
VARICOSE VEINS Y N
HIGH BLOOD PRESSURE Y N
OTHER _____

INTEGUMENTARY

SKIN RASH Y N
BOILS Y N
PERSISTENT ITCH Y N
OTHER _____

MUSCULOSKELETAL

JOINT PAIN Y N
NECK PAIN Y N
BACK PAIN Y N
OTHER _____

EAR/NOSE/THROAT/MOUTH

EAR INFECTION Y N
SORE THROAT Y N
SINUS PROBLEMSY N
OTHER _____

GENITOURINARY

URINE RETENTION Y N
PAINFUL URINATION Y N
URINARY FREQUENCY Y N
OTHER _____

RESPIRATORY

WHEEZING Y N
FREQUENT COUGH Y N
SHORTNESS OF BREATH Y N
OTHER _____

HEMATOLOGIC/LYMPHATIC

SWOLLEN GLANDS Y N
BLOOD CLOTTING PROBLEM Y N
OTHER _____

PHYSICIAN USE ONLY (COMMENTS/NOTES)

PHYSICIAN: _____ DATE: _____