REVIEW OF SYSTEMS

If you are having any of the following problems at this time, please place a check on the line in front of it. Also, fill in the blanks where indicated.

SKIN AND HAIR:

- ___ Bruise easily
- ___ Sores or wounds that don't heal
- ___ Any growths that bother you?
- ___ Skin color changes
- ___ Rashes/Hives/Pimples
- ___ Itching
- ___ Loss of hair
- ___ Dry
- ___ Oily
- ___ Other:_____
- _____

HEAD/EARS/EYES/NOSE/THROAT:

- ___ Dizziness/Vertigo
- ___ Headaches/Migraines
- ___ Facial pain
- ___ Ringing in ears
- ___ Earaches
- ___ Poor hearing
- ___ Jaw clicks
- ___ Poor vision
- ___ Eye pain
- ___ Spots in eyes
- ___ Nasal stuffiness
- ___ Loss of smell
- ___ Sores on lips/tongue
- ___ Gum problems
- ___ Nose bleeds
- ___ Bleeding gums
- ___ Recurrent sore throats
- ___ Dry throat/mouth
- ___ Lots of saliva
- ___ Persistent hoarseness
- ___ Grinds teeth

HEART/CIRCULATION

- ___ High blood pressure
- ___ Low blood pressure
- ___ Dizziness
- ___ Fainting
- ___ Lethargy
- ___ Chest pain/tightness/pressure
- ___ Fast or irregular heartbeat
- ___ Feelings of heat
- ___ Feelings of cold
- ___ Bleeding disorder
- ___ Hot soles and palms
- ___ Leg vein trouble (phlebitis)
- ___ Leg pain when walking
- ___ Swelling in hands/feet

RESPIRATORY

- ___ Daily cough
- ___ Coughing with blood
- ___ Frequent chest colds
- ___ Production of phlegm/sputum – What color? _____
- ___ Asthma
- ___ Shortness of breath
- ___ Difficulty breathing
- ___ Tight chest
- ___ Bronchitis

GASTROINTESTINAL

- ___ Nausea
- ___ Vomiting
- ___ Poor appetite
- ___ Belching
- ___ Hemorrhoids
- ___ Bloody stools
- ___ Trouble swallowing
- ___ Bad breath
- ___ Bloated after meals
- ___ Loose stools
- ___ Gas/Cramping
- ___ Black Stools

Bowel movements:
Frequency:_____

- ___ Rectal Pain
- ___ Other pain – where?____
- _____
- ___ Distress from fats or greasy foods

MUSCULOSKELETAL

- ___ Joint paind/stiffness
- ___ Muscle pain
- ___ Localized weakness
- ___ Numbness/tingling
- ___ Pain interferes with normal daily activities
- ___ Neck pain
- ___ Upper back pain
- ___ Lower back pain
- ___ Leg pain

___ Locations of problems/other (list below):

_____
_____
_____

NEUROPSYCHOLOGICAL

- ___ Seizures
- ___ Poor memory
- ___ Frequent headaches
- ___ Easily stressed
- ___ Depression
- ___ Anxiety/Fear
- ___ Bad temper
- ___ Crying spells
- ___ Overwhelming joy
- ___ Treated for emotional problems
- ___ Concussion
- ___ Don't know how to relieve stress

GENITO-URINARY

- ___ Painful/burning urination
- ___ Blood in urine
- ___ Urgency to urinate
- ___ Frequent urination
- ___ Wake up to urinate at night _____ times.
- ___ Difficulty urinating
- ___ Kidney stones
- ___ Urine scanty and dark
- ___ VD

MEN:

- ___ Prostate trouble
- ___ Discharge from penis
- ___ Impotency

PREGNANCY/GYNECOLOGICAL

- ___ Vaginal discharge
- ___ Vaginal sores
- ___ Breast lumps
- ___ Nipple discharge
- No. pregnancies _____
- No. births _____
- No. stillborns/abortions _____
- ___ Birth control used. Type _____
- ___ Menopause
- ___ Premenstrual changes in body/psyche
- Last PAP smear _____
- Last menses _____

Period:

- Every _____ days
- Lasts _____days

(Circle one in each category below)

- Regular or Irregular
- Flow: Excessive Scanty Normal
- Blood dark or bright red
- Clots present? YES NO
- Painful menstruation? YES NO

GENERAL

- ___ Chills and fever
- ___ Night sweats
- ___ Sweats easily at any time
- ___ Weight loss or gain
- ___ Strong thirst
- ___ Sudden energy drop at _____ (time of day)
- ___ Swollen glands
- ___ Easily fatigued