

Patient Name: _____ Appointment Date: ____/____/____

Account #: _____

Review of Systems: Please check [] any of the following symptoms you are having:

<p>Constitutional</p> <ul style="list-style-type: none"> <input type="checkbox"/> unexplained weight loss: _____lbs. <input type="checkbox"/> unexplained weight gain: _____lbs. <input type="checkbox"/> night sweats <input type="checkbox"/> fevers/chills <input type="checkbox"/> loss of appetite <input type="checkbox"/> NONE 	<p>Integumentary</p> <ul style="list-style-type: none"> <input type="checkbox"/> rashes <input type="checkbox"/> frequent bruising <input type="checkbox"/> hives <input type="checkbox"/> sores that don't heal <input type="checkbox"/> NONE 	<p>Neurological</p> <ul style="list-style-type: none"> <input type="checkbox"/> headache <input type="checkbox"/> blackouts and fainting <input type="checkbox"/> tingling / numbness <input type="checkbox"/> paralysis <input type="checkbox"/> seizures <input type="checkbox"/> memory loss <input type="checkbox"/> NONE
<p>Eyes</p> <ul style="list-style-type: none"> <input type="checkbox"/> blurry vision <input type="checkbox"/> double vision <input type="checkbox"/> eye pain <input type="checkbox"/> NONE 	<p>Cardiovascular</p> <ul style="list-style-type: none"> <input type="checkbox"/> chest pain/pressure/tightness <input type="checkbox"/> palpitations <input type="checkbox"/> trouble breathing while lying <input type="checkbox"/> NONE 	<p>Ear/Nose/Throat</p> <ul style="list-style-type: none"> <input type="checkbox"/> vertigo/dizziness <input type="checkbox"/> ringing in the ear <input type="checkbox"/> nose bleed <input type="checkbox"/> sinusitis <input type="checkbox"/> trouble swallowing <input type="checkbox"/> hearing aid <input type="checkbox"/> NONE
<p>Respiratory</p> <ul style="list-style-type: none"> <input type="checkbox"/> shortness of breath <input type="checkbox"/> COPD <input type="checkbox"/> chronic cough <input type="checkbox"/> NONE 	<p>Psychological</p> <ul style="list-style-type: none"> <input type="checkbox"/> depression <input type="checkbox"/> anxiety <input type="checkbox"/> NONE 	<p>Gastrointestinal</p> <ul style="list-style-type: none"> <input type="checkbox"/> stomach pain/heart burn <input type="checkbox"/> bloody or dark stools <input type="checkbox"/> constipation <input type="checkbox"/> diarrhea <input type="checkbox"/> nausea/vomiting <input type="checkbox"/> NONE
<p>Musculoskeletal</p> <ul style="list-style-type: none"> <input type="checkbox"/> joint pain <input type="checkbox"/> joint redness and swelling <input type="checkbox"/> leg pain with walking <input type="checkbox"/> muscle cramps <input type="checkbox"/> weakness <input type="checkbox"/> NONE 	<p>Genitourinary</p> <ul style="list-style-type: none"> <input type="checkbox"/> blood in the urine <input type="checkbox"/> painful urination <input type="checkbox"/> urgency to urinate <input type="checkbox"/> loss of bladder control <input type="checkbox"/> frequent urination <input type="checkbox"/> difficulty urinating <input type="checkbox"/> NONE 	

I acknowledge, I have reviewed the above information and have completed the form to the best of my ability.

Patient Signature

M.D. Signature

For Clinical Use only

Ht. _____ Wt. _____ B/P _____ P _____ BMI: _____