Name: ______________________________ **Date:** ______________________________

REVIEW OF SYSTEMS: If you are currently having any problems in the following areas, circle and explain (if necessary).

SKIN: itching, rash, infection, ulcer, tumors (growths), other Explain:	❑ none
LYMPH NODES: swelling, tenderness, other Explain	❑ none
BONES, JOINTS, MUSCLES: muscle pain/cramps, joint pain/swelling, other Explain:	❑ none
ENDOCRINE: fatigue, confusion, fainting, nervousness, hot/cold intolerance, hair loss, excessive hair growth, other Explain:	❑ none
ALLERGY/IMMUNOLOGY: recurrent infections, hayfever, hives, food allergy, drug sensitivity/allergy, other Explain:	❑ none
HEAD: headaches, dizziness, vertigo, other Explain:	❑ none
EARS: hearing loss, ringing, infections, other **NOSE**: bleeding, loss of smell, congestion, other **THROAT**: dry mouth, loss of taste, difficulty swallowing, hoarseness, other Explain:	❑ none ❑ none ❑ none
NECK: pain swelling stiffness, other Explain:	❑ none
BREASTS: tenderness, swelling, lumps, discharge, other Explain:	❑ none
BLOOD: fever/chills, easy bruisability, prolonged bleeding, skin hemorrhages, significant blood loss, other Explain:	❑ none
RESPIRATORY: wheezing cough (productive/blood), difficulty breathing, other Explain:	❑ none
CARDIOVASCULAR (HEART/BLOOD VESSELS): chest pain, cold hands/feet, swelling of extremities, shortness of breath, exercise intolerance, other Explain:	❑ none
GASTROINTESTINAL (STOMACH/INTESTINES): nausea, vomiting, change in bowel habits, constipation, diarrhea, bleeding, pain/cramps, other Explain:	❑ none
GENITOURINARY (GENITALS/KIDNEYS/BLADDER): frequency, burning, hesitancy, pain or bleeding on urination, stones, infections, incontinence, impotence, other Explain:	❑ none
NERVOUS SYSTEM: weakness in arms/legs, numbness/tingling, loss of consciousness, falls, difficulty walking, seizures, tremors, neuralgia, other Explain:	❑ none
PSYCHIATRIC: disorientation, mood swings, anxiety, depression, hallucinations, other Explain:	❑ none

This form completed by: ______________________________

To be completed by physician: ________________ History Reviewed: ____________ Date: ____________