PATIENT NAME: _____

DATE: _____

REVIEW OF SYSTEMS

Do you now or have you had any problems related to the following systems? Please Circle Yes or No and explain any Yes answers in the space provided. If additional space is needed, please use the back of this page. This page must be completed in full prior to consultation with the Doctor.

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*	*Sometimes*
*Other*_____			

CARDIOVASCULAR

Chest Pain	*Y*	*N*
Varicose Veins	*Y*	*N*
High Blood Pressure	*Y*	*N*

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 Problems	*Y*	*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*
Hepatitis B	*Y*	*N*
Hepatitis C	*Y*	*N*
HIV	*Y*	*N*
*Other*_____		

PSYCHOLOGIC

Are you Generally Satisfied with your life?	*Y*	*N*
Do you Feel Severely Depressed?	*Y*	*N*
Considered Suicide?	*Y*	*N*

Physician Use Only: (Comments/Notes)

#Answer	*Level of Service*
0 - 1	*1 or 2*
2 - 9	*3*
10+	*4 or 5*

*PHYSICIAN:*_____ *DATE:* ____/____/____