REVIEW OF SYSTEMS

In each area if you are experiencing any of the symptoms listed, PLEASE CIRCLE THE ONES THAT APPLY, or explain any that may not be listed. If you have any questions about this, please ask the medical assistant, or your doctor.

General Health: Fever, chills, fatigue, weakness. Other: ________________________

Eyes: Vision loss 1 eye, double vision, vision loss both eyes, blurring, light sensitivity, macular degeneration. Other: ________________________

Ear/Nose/Throat: Ringing in ears, ear discharge, bleeding, earache, decreased hearing, ear itching. Other: ________________________

Cardiovascular: Near fainting, chest pain or discomfort, racing/skipping heart beats, light headedness, palpitations, fainting. Other: ________________________

Respiration: Sleep disturbances due to breathing, shortness of breath, chest discomfort, wheezing. Other: ________________________

Gastrointestinal: Excessive appetite, loss of appetite, indigestion, vomiting blood, nausea, vomiting. Other: ________________________

Genitourinary: Foul urinary discharge, blood in urine, urinary frequency, urinary urgency, kidney pain. Other: ________________________

Musculoskeletal: Muscle cramps, joint pain, joint swelling, back pain, stiffness, muscle weakness, arthritis, gout, loss of strength. Other: ________________________

Dermatology: Night sweats, suspicious lesions, dryness, poor wound healing, unusual hair distribution, skin cancer. Other: ________________________

Neurological: Difficulty with concentration, poor balance, headaches, disturbances in coordination, numbness, inability to speak, falling down, tingling, visual disturbances seizures, weakness, sensation of room spinning, tremors, fainting, excessive daytime sleeping, memory loss. Other: ________________________

Psychological: Anxiety, depression. Other: ________________________

Endocrine: Excessive hunger, cold intolerance, heat, intolerance, excessive urination, excessive thirst, weight change. Other: ________________________

Hematology: Enlarged lymph nodes, bleeding, skin discoloration, abnormal bruising, fevers. Other: ________________________

Allergy: Persistent infections, hives or rash, seasonal allergies, HIV exposure. Other: ________________________

Smoking: Never, Some days, Every day (packs per day _________), Former (year quit _________)