Review of Systems: Indicate personal history below, circling the appropriate answer

GENERAL HEALTH		
Fever	Yes	No
Chills	Yes	No
Sweats	Yes	No
Anorexia	Yes	No
Fatigue / Weakness	Yes	No
Weight Loss	Yes	No
Sleep Disorder	Yes	No

EYES		
Blurred Vision	Yes	No
Double Vision / Diplopia	Yes	No
Irritation	Yes	No
Discharge	Yes	No
Vision Loss	Yes	No
Eye Pain	Yes	No

EAR, NOSE & THROAT		
Earache	Yes	No
Ear Discharge	Yes	No
Ringing of ears / Tinnitus	Yes	No
Decreased Hearing	Yes	No
Nasal Congestion	Yes	No
Nosebleeds	Yes	No
Sore Throat	Yes	No
Hoarseness	Yes	No

CARDIOVASCULAR		
Chest Pains	Yes	No
Palpitations	Yes	No
Fainting / Syncope	Yes	No
Shortness of breath with activity	Yes	No
Shortness of breath lying down	Yes	No
Swelling (edema)	Yes	No

RESPIRATORY		
Cough	Yes	No
Shortness of breath with rest	Yes	No
Excessive Sputum	Yes	No
Spitting up blood/Hemoptysis	Yes	No
Wheezing	Yes	No
<<Affix Label Here>>		

GASTROINTESTINAL		
Nausea	Yes	No
Vomiting	Yes	No
Diarrhea	Yes	No
Constipation	Yes	No
Change in bowel habits	Yes	No
Abdominal Pain	Yes	No
Blood in stool/hematochezia	Yes	No
Jaundice	Yes	No
Gas/Bloating	Yes	No
Indigestion/Heartburn	Yes	No

GENITOURINARY FEMALE		
Vaginal Discharge	Yes	No
Incontinence/Dribbling	Yes	No
Painful Urnination / Dysuria	Yes	No
Blood in Urine / Hematuria	Yes	No
Female-Irregular Periods/Amenorrhea	Yes	No
Female-Pain with Periods/Menorrhagia	Yes	No
Abnormal Vaginal Bleeding	Yes	No
Pelvic Pain	Yes	No
Genital Sores	Yes	No
Decreased Libido	Yes	No

MALE		
Painful Urnination / Dysuria	Yes	No
Blood in Urine / Hematuria	Yes	No
Discharge	Yes	No
Urinary Frequency	Yes	No
Urinary Hesitancy	Yes	No
Nocturia	Yes	No
Incontinence/Dribbling	Yes	No
Genital Sores	Yes	No
Decreased Libido	Yes	No
Erectile Dysfunction	Yes	No

MUSCULOSKELETAL		
Back Pain	Yes	No
Joint Pain	Yes	No
Joint Swelling	Yes	No
Muscle Cramps	Yes	No
Muscle Weakness	Yes	No
Stiffness	Yes	No
Arthritis	Yes	No
Sciatica	Yes	No
Restless Legs	Yes	No
Leg pain at night	Yes	No
Leg pain with exertion	Yes	No

DERMATOLOGIC		
Rash	Yes	No
Itching	Yes	No
Dryness	Yes	No
Suspicious Lesions	Yes	No

NEUROLOGICAL		
Paralysis	Yes	No
Numbness/Paresthesias	Yes	No
Seizures	Yes	No
Tremors	Yes	No
Vertigo	Yes	No
Transient Blindness	Yes	No
Frequent Falls	Yes	No
Frequent Headaches	Yes	No
Difficulty Walking	Yes	No

PSYCHOLOGICAL		
Depression	Yes	No
Anxiety	Yes	No
Memory Loss	Yes	No
Suicidal Ideation	Yes	No
Hallucinations	Yes	No
Paranoia	Yes	No
Phobia	Yes	No
Confusion	Yes	No

ENDOCRINE		
Cold Intolerance	Yes	No
Heat Intolerance	Yes	No
Excessive Thirst/Polydipsia	Yes	No
Frequent Urination/Polyuria	Yes	No
Unusual Weight Change	Yes	No

HEMATOLOGIC		
Abnormal Bruising	Yes	No
Bleeding	Yes	No
Enlarged Lymph Nodes	Yes	No

ALLERGIES		
Itching/Urticaria	Yes	No
Allergic Rash	Yes	No
Hay Fever	Yes	No
Recurrent Infections	Yes	No

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.