Patients NEW to our office or RETURN patients not seen in the last 3 years

NAME____________________________________DATE___________________

REVIEW OF SYSTEMS—Do you have problems with any of the following:

Allergic/Immunologic

Hay Fever/Allergies	Yes	No
Medication Allergies	Yes	No

Constitutional Symptoms

Fever	Yes	No
Weight Loss	Yes	No

Cardiovascular

Chest Pain	Yes	No
High Blood Pressure	Yes	No
High Cholesterol	Yes	No
Vascular Disease	Yes	No

Ears, Nose, Mouth, Throat

Sinus Problems	Yes	No
Chronic Cough	Yes	No
Dry Mouth	Yes	No
Chronic Ear Infections	Yes	No
Sleep Apnea	Yes	No

Endocrine

Diabetes	Yes	No
Thyroid	Yes	No
Swollen Glands	Yes	No

Gastrointestinal

Diarrhea	Yes	No
Constipation	Yes	No
Ulcers	Yes	No

Genitourinary

Genitals	Yes	No
Kidney	Yes	No
Bladder	Yes	No

Hematologic/Lymphatic

Anemia	Yes	No
Bleeding	Yes	No
Swelling	Yes	No

Integumentary

Skin Rashes	Yes	No
Breast Problems	Yes	No

Musculoskeletal

Arthritis	Yes	No
Rheumatoid	Yes	No
Muscle Pain	Yes	No
Joint Pain	Yes	No

Neurological

Headaches	Yes	No
Migraines	Yes	No
Seizures	Yes	No

Psychiatric

Nervous Disorders	Yes	No
Depression	Yes	No
Anxiety	Yes	No
Compulsiveness	Yes	No

Respiratory

Asthma	Yes	No
Shortness of Breath	Yes	No
Emphysema	Yes	No
Lung Cancer	Yes	No