Review of Systems
Today, do you have any problems in the following areas?

1. **Eyes**
   - Sudden loss or change in vision
   - Burning or itching; excessive tearing
   - Redness
   - Discharge
   - Swelling of lid or growth

2. **Constitutional**
   - Fever
   - Weight loss
   - Weight gain
   - Night sweats
   - Are you feeling well today? yes or no

3. **Ears, nose, mouth and throat**
   - Sinus pressure/congestion
   - Hearing loss
   - Dry mouth
   - Nose bleeds

4. **Cardiovascular**
   - Chest pain
   - Shortness of breath
   - Exercise intolerance
   - Dependent ankle swelling

5. **Respiratory**
   - Cough sputum, blood
   - Wheezing
   - Shortness of breath

6. **Gastrointestinal**
   - Nausea/vomiting
   - Diarrhea
   - Abdominal pain
   - Bloody stools

7. **Genitourinary**
   - Trouble controlling urination
   - Blood in urine
   - Pain with urination
   - Difficulty emptying

8. **Integumentary**
   - Rash non/pruritic
   - Excessive dryness
   - Discoloration
   - Bumps or nodules

9. **Neurological**
   - Headache
   - Loss of balance
   - Weakness
   - Seizures

10. **Musculoskeletal**
    - Arthritis
    - Pain or swelling
    - Loss of range of motion

11. **Hematologic/lymphatic**
    - Increased frequency of infections
    - Non-healing wounds
    - Excessive bleeding
    - Excessive clottings

12. **Psychiatric**
    - Depression
    - Anxiety
    - Difficulty sleeping

13. **Endocrine**
    - Increased urination or thirst
    - Palpitations
    - Anxiety
    - Weight loss or weight gain

14. **Allergic/Immunologic**
    - Allergies to new medicines/foods/clothing
    - Hay fever
    - Seasonal
    - Environmental
    - Allergic to latex or adhesives

Please list all allergies to medications and side effects.
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Signature of Patient:__________________________

Signature of Doctor:__________________________