

REVIEW OF SYSTEMS

Today's Date: ____/____/____

Name: _____ Date of Birth: ____/____/____ Age: _____

Problems you (the patient) had in the past/are currently experiencing:

General	Past	Present	Never	Cardiovascular	Past	Present	Never
Weight loss/gain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chest pain/discomfort	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tightness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fever or chills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Palpitations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Weakness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath			
Trouble sleeping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	with activity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Head	Past	Present	Never	Gastrointestinal	Past	Present	Never
Headache	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Swallowing difficulties	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Head Injury	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heartburn	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Concussion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Change in appetite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neck pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nausea/vomiting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eyes	Past	Present	Never	Constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vision loss/changes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Musculoskeletal	Past	Present	Never
Redness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Muscle or joint pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blurry vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Muscle weakness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Double vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Trauma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Flashing lights	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Neurological	Past	Present	Never
Specks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fainting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Throat, Mouth,				Weakness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nose, & Ears	Past	Present	Never	Numbness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tremor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sore tongue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mental Health	Past	Present	Never
Dry mouth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nervousness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sore throat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stress	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hoarseness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sinus pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Memory loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Decreased hearing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ringling in ears	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Allergy	Past	Present	Never
Respiratory	Past	Present	Never	Persistent infections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hives	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sputum	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Seasonal Allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				

PATIENT OR PARENT/ GUARDIAN SIGNATURE: _____