Patient Name: _____ Date: _____

PATIENT REVIEW OF SYSTEMS

Do you consider your self generally: □ □ Healthy □□ Not Healthy □ Other:_____

Have you ever experienced or are you experiencing any of the following: *(Check all that apply)*

Eyes	□□ Blurred Vision	□□ Painful eyes	□□ Irritation from light
□ **NONE**		□ Other_____	
Ears, Nose, Mouth	□□ Pressure in ears	□□ Itching	□□ Nose blocked
or Throat	□□ Runny nose	□□ Sores in mouth	□□ Post nasal drainage
□ NONE	□□ Teeth hurt	□□ Grinding teeth	□□ Difficulty swallowing
	□□ Painful swallowing	□ Other _____	
Cardiovascular (Heart)	□□ Heart palpitations	□ Pain in the chest	□ □□ Shortness of breath while exercising
□ NONE	□	□ Other _____	
Respiratory (lung)	□□ Cough	□ □ Wheezing	□ □ Shortness of breath while sitting
□ NONE	□	□ Other _____	
Gastrointestinal (Stomach)	□ □ Acid reflux	□ □ Constipation	□ □ Diarrhea
□ NONE	□ □ Abdominal pain	□ Other _____	
Genitourinary (Bladder)	□ □ Pain when urinating	□ Hesitation when urinating	
□ NONE	□ □ Urination at night	□ Other _____	
Musculoskeletal	□ □ Cramping	□ □ Soreness	□ □ Weakness
□ NONE	□	□ Other _____	
Skin	□ □ Dry skin	□ □ Itchy skin	□ □ Lesions on skin
□ NONE	□ □ Bleeding	□ Other _____	
Neurological (Nerves)	□ □ Twitch	□ □ Abnormal movements	□ □ Ringing in ears
□ NONE	□□ Dizziness / Vertigo	□ Other _____	
Psychiatric	□ □ Depression	□□ Mood swings	□□ Situational stress
□ NONE	□	□ Other _____	
Endocrine	□ □ Hot flashes	□ □ Hair loss / growth	□ □ Heat
□ NONE	□ □ Cold	□ Other _____	
Hematologic / Lymph nodes	□ □ Bleeding easily	□ Night sweats	□
□ NONE	□	□ Other _____	
Allergic / Immunologic	□ □ Sneezing	□□ Skin reaction	□□ Eye irritation / itchiness
□ NONE	□	□ Other__ _____	

For Office Use Only **Reviewed/Updates**

____/____/____;____	____/____/____;____	____/____/____;____	____/____/____;____
____/____/____;____	____/____/____;____	____/____/____;____	____/____/____;____