Name _____ Date_____

## Review of Systems

***Constitutional***

___Fevers/Chills/Sweats

___Unexplained weight loss/gain

___Fatigue/weakness

___Excessive thirst or urination

***Musculo-SKeletal***

___Muscle/Joint Pain

***Ears/Nose/Throat***

___Difficulty hearing/ringing

___Hay Fever/Allergies

***Cardiovascular***

___Chest Pain/Discomfort

___Leg Pain w/Exercise

___Palpitations

***Other*** (please specify)

_____

_____

***Dental***

___Extractions

___Crowns

___Root Canal

___Gum Disease

___Fillings

___Other

***Respiratory***

___Cough/Wheeze

___Difficulty Breathing

***Gastrointestinal***

___Heartburn/Reflux

___Nausea/Vomiting/Diarrhea

___Abdominal Pain

***Skin***

___Rash or Mole

***Neurological***

___Numbness

___Headaches

___Dizziness

___Memory Loss

__Loss of Coordination

***Blood/Lymphatic***

___Unexplained Lumps

__Easy Bruising

***Eyes***

___Change in Vision

***Psychiatric***

___Anxiety/Stress

___Problems with sleep

___Depression

***General Medical History: Past and Current medical problems (please include dates)***

___Heart Disease: (specify)

_____

___Asthma/Lung Disease

___Accidents

___Other: (specify)

___High Blood Pressure

___Diabetes

___Chemical Exposure

___Injuries

___High Cholesterol

___Thyroid Problem

___Kidney Disease

___Cancer: (specify)

_____

***Family History: Please indicate the current status of your immediate family members (Mother, Father, Sibling, Grandparent, Aunt, Uncle)***

___Alcoholism

___Heart Disease

___Cancer: type _____

___Depression/Suicide

___Asthma/COPD

___High Cholesterol

___Stroke

___Bleeding or Clotting

___Other

___High Blood Pressure

___Diabetes

___Genetic Disorders

**Signature**_____