

Patient Name: \_\_\_\_\_ DATE: \_\_\_\_\_

### Review of Systems

Please check any symptoms you are currently experiencing:

#### Constitutional

- Lack of energy    Trouble sleeping    Loss of appetite    Weight changes    Fevers

#### HEENT

- Double or blurred vision    Buzzing or ringing in ears    Allergies/Hay fever  
 Sinus problems

#### Cardiovascular

- Chest pain    Palpitations    High blood pressure    Swollen legs

#### Respiratory

- Wheezing    Coughing    Coughing blood    Shortness of breath

#### Digestive

- Indigestion    Change in bowel habits    Bloody or tarry stools

#### Urinary

- Urinary frequency    Urinary infections

#### Musculoskeletal

- Joint pains, swelling, or redness    Muscle aches or tenderness

#### Dermatological

- Rash, itching or other skin problems

#### Neurological

- Numbness, tingling    Loss of balance    Seizures    Loss of memory    Headaches

#### Psychiatric

- Nervousness    Depression

#### Endocrinology

- Thyroid disorder    Excess thirst    Excess hunger    Excess urination

#### Hematological

- Bleeding    Easy bruising    Anemia

PATIENT HEIGHT \_\_\_\_\_ PATIENT WEIGHT \_\_\_\_\_

I certify that all information above on this sheet is, to the best of my knowledge, true and correct.

Patient Signature: \_\_\_\_\_