**Review of Systems**

<table>
<thead>
<tr>
<th><strong>Patient Name:</strong></th>
<th><strong>DATE:</strong></th>
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*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

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

Height ________________________  Weight ________________

**Patient Signature:** ___________________________________________________________