Name: _____Date: _____

DOB: _____ Primary Physician: _____

REVIEW OF SYSTEMS

If you have any recent problems with the following issues, check the problem(s) listed. If you DO NOT have any recent problems with these issues, check the NO PROBLEM BOX.

Lungs:
{ } Shortness of Breath
{ } Wheezing
{ } Sleep Apnea
{ } Cough
{ } Asthma
{ } Coughing Blood
{ } Snoring
{ } No Problem

Stomach, Intestines, Colon:
{ } Nausea
{ } Vomiting
{ } Vomiting Blood
{ } Diarrhea
{ } Constipation
{ } Food Intolerance
{ } Rectal Bleeding
{ } Change in Bowel Habits
{ } Indigestion
{ } No Problem

Muscle, Joints, Bones:
{ } Limitation of Joint or Muscle Movement
{ } Joint Swelling or Redness
{ } Bone Pain
{ } No Problem

Urinary:
{ } Frequent or Painful Urination
{ } Losing Control of Urine/Wetting Self
{ } Frequent Urination at Night
{ } Blood in Urine
{ } No Problem

Heart & Circulation:
{ } Chest Pain, Tightness or Pressure
{ } Fast or Slow Heartbeat/Irregular Heartbeat
{ } Ankle Swelling
{ } High Blood Pressure
{ } Low Blood Pressure
{ } No Problem

General:
{ } Unusual Weight Changes
{ } Fatigue
{ } Fever
{ } Pain
{ } Weakness
{ } No Problem

Nervous System:
{ } Fainting
(} Seizures/Epilepsy
{ } Headaches
{ } Blackouts
{ } Tremors
{ } Paralysis
{ } Memory Loss
{ } No Problem