

MEDICAL REVIEW OF SYSTEMS

Name: _____

Date of Birth: _____

Today's Date: _____

Do you currently have any problems in the following areas?

	<u>Yes</u>	<u>No</u>		<u>Yes</u>	<u>No</u>
<u>EYES</u>					
Loss of Central Vision			<u>GASTROINTESTINAL</u>		
Loss of Side Vision			Swallowing Difficulty		
Distorted Vision or Halos			Vomiting/Heartburn		
Fluctuating Vision			Diarrhea/Constipation		
Flashes or Floaters			Jaundice		
Eye Pain or Soreness			<u>GENITO-URINARY</u>		
Light Sensitivity			Urinary Frequency		
Double Vision			Urinary Pain or Blood		
Crossing or Drifting of Eyes			Men-		
Redness			Discharge, Lesions, Masses		
Discharge			Women-		
Foreign Body Sensation			Currently Pregnant		
Sandy or Gritty Feeling			Breast Masses or Discharge		
Itching			Vaginal Bleeding, Discharge		
Burning			<u>MUSCULOSKELETAL</u>		
Excess Tearing/Watering			Joint Pain, Swelling, or Redness		
Glare			Muscle Pain or Cramps		
Styes			<u>NEUROLOGICAL</u>		
Other _____			Headaches		
<u>CONSTITUTIONAL SYSTEMS</u>			Numbness or Tingling		
Fever			Weakness or Paralysis		
Weight Loss or Gain			Fainting or Blackouts		
Fatigue			Slurred Speech		
<u>SKIN</u>			<u>PSYCHIATRIC</u>		
Rashes or Color Changes			Anxiety		
Itching or Dryness			Depression		
Hair or Nail Changes			Other _____		
<u>EARS, NOSE, MOUTH, THROAT</u>			<u>ENDOCRINE</u>		
Hearing Difficulty			Heat or Cold Intolerance		
Ringing or Vertigo			Excessive Thirst or Hunger		
Sinus Congestion			<u>HEMATOLOGICAL/LYMPHATICS/IMMUNOLOGY</u>		
Runny Nose/Post-nasal drip			Easy Bruising/Bleeding		
Nose Bleeds			Blood Transfusions		
Dry Throat/Mouth			Swollen Lymph Nodes		
Hoarseness			Other Symptoms Not Listed Above:		
Pain in jaw when chewing			_____		
<u>CARDIOVASCULAR (HEART/BLOOD VESSELS)</u>			_____		
Chest Pain or Palpitations			_____		
Other _____					
<u>RESPIRATORY (LUNGS/BREATHING)</u>					
Cough					
Shortness of Breath					
Wheezing					