

**MEDICAL REVIEW OF SYSTEMS**

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Today's Date: \_\_\_\_\_

Do you currently have any problems in the following areas?

<u>EYES</u>	<u>Yes</u>	<u>No</u>
Loss of Central Vision	<input type="checkbox"/>	<input type="checkbox"/>
Loss of Side Vision	<input type="checkbox"/>	<input type="checkbox"/>
Distorted Vision or Halos	<input type="checkbox"/>	<input type="checkbox"/>
Fluctuating Vision	<input type="checkbox"/>	<input type="checkbox"/>
Flashes or Floaters	<input type="checkbox"/>	<input type="checkbox"/>
Eye Pain or Soreness	<input type="checkbox"/>	<input type="checkbox"/>
Light Sensitivity	<input type="checkbox"/>	<input type="checkbox"/>
Double Vision	<input type="checkbox"/>	<input type="checkbox"/>
Crossing or Drifting of Eyes	<input type="checkbox"/>	<input type="checkbox"/>
Redness	<input type="checkbox"/>	<input type="checkbox"/>
Discharge	<input type="checkbox"/>	<input type="checkbox"/>
Foreign Body Sensation	<input type="checkbox"/>	<input type="checkbox"/>
Sandy or Gritty Feeling	<input type="checkbox"/>	<input type="checkbox"/>
Itching	<input type="checkbox"/>	<input type="checkbox"/>
Burning	<input type="checkbox"/>	<input type="checkbox"/>
Excess Tearing/Watering	<input type="checkbox"/>	<input type="checkbox"/>
Glare	<input type="checkbox"/>	<input type="checkbox"/>
Styes	<input type="checkbox"/>	<input type="checkbox"/>
Other _____		

CONSTITUTIONAL SYSTEMS

Fever	<input type="checkbox"/>	<input type="checkbox"/>
Weight Loss or Gain	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>

SKIN

Rashes or Color Changes	<input type="checkbox"/>	<input type="checkbox"/>
Itching or Dryness	<input type="checkbox"/>	<input type="checkbox"/>
Hair or Nail Changes	<input type="checkbox"/>	<input type="checkbox"/>

EARS, NOSE, MOUTH, THROAT

Hearing Difficulty	<input type="checkbox"/>	<input type="checkbox"/>
Ringing or Vertigo	<input type="checkbox"/>	<input type="checkbox"/>
Sinus Congestion	<input type="checkbox"/>	<input type="checkbox"/>
Runny Nose/Post-nasal drip	<input type="checkbox"/>	<input type="checkbox"/>
Nose Bleeds	<input type="checkbox"/>	<input type="checkbox"/>
Dry Throat/Mouth	<input type="checkbox"/>	<input type="checkbox"/>
Hoarseness	<input type="checkbox"/>	<input type="checkbox"/>
Pain in jaw when chewing	<input type="checkbox"/>	<input type="checkbox"/>

CARDIOVASCULAR (HEART/BLOOD VESSELS)

Chest Pain or Palpitations	<input type="checkbox"/>	<input type="checkbox"/>
Other _____		

RESPIRATORY (LUNGS/BREATHING)

Cough	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>
Wheezing	<input type="checkbox"/>	<input type="checkbox"/>

GASTROINTESTINAL                      Yes      No

Swallowing Difficulty	<input type="checkbox"/>	<input type="checkbox"/>
Vomiting/Heartburn	<input type="checkbox"/>	<input type="checkbox"/>
Diarrhea/Constipation	<input type="checkbox"/>	<input type="checkbox"/>
Jaundice	<input type="checkbox"/>	<input type="checkbox"/>

GENITO-URINARY

Urinary Frequency	<input type="checkbox"/>	<input type="checkbox"/>
Urinary Pain or Blood	<input type="checkbox"/>	<input type="checkbox"/>

Men-

Discharge, Lesions, Masses	<input type="checkbox"/>	<input type="checkbox"/>
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Women-

Currently Pregnant	<input type="checkbox"/>	<input type="checkbox"/>
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Breast Masses or Discharge	<input type="checkbox"/>	<input type="checkbox"/>
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Vaginal Bleeding, Discharge	<input type="checkbox"/>	<input type="checkbox"/>
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MUSCULOSKELETAL

Joint Pain, Swelling, or Redness	<input type="checkbox"/>	<input type="checkbox"/>
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Muscle Pain or Cramps	<input type="checkbox"/>	<input type="checkbox"/>
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NEUROLOGICAL

Headaches	<input type="checkbox"/>	<input type="checkbox"/>
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Numbness or Tingling	<input type="checkbox"/>	<input type="checkbox"/>
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Weakness or Paralysis	<input type="checkbox"/>	<input type="checkbox"/>
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Fainting or Blackouts	<input type="checkbox"/>	<input type="checkbox"/>
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Slurred Speech	<input type="checkbox"/>	<input type="checkbox"/>
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PSYCHIATRIC

Anxiety	<input type="checkbox"/>	<input type="checkbox"/>
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Depression	<input type="checkbox"/>	<input type="checkbox"/>
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Other \_\_\_\_\_

ENDOCRINE

Heat or Cold Intolerance	<input type="checkbox"/>	<input type="checkbox"/>
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Excessive Thirst or Hunger	<input type="checkbox"/>	<input type="checkbox"/>
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HEMATOLOGICAL/LYMPHATICS/IMMUNOLOGY

Easy Bruising/Bleeding	<input type="checkbox"/>	<input type="checkbox"/>
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Blood Transfusions	<input type="checkbox"/>	<input type="checkbox"/>
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Swollen Lymph Nodes	<input type="checkbox"/>	<input type="checkbox"/>
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Other Symptoms Not Listed Above:

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Please list all medications/vitamins/herbals and the dosages, as well as any allergies: \_\_\_\_\_

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