REVIEW OF SYSTEMS

Patient Name:
Date of Birth:
Chart Number:

Please indicate if you have any of the symptoms listed below, return to staff.

1. Constitutional Fatigue or weight loss Yes❑ No❑
If yes, please explain________________________________

2. Eyes Blurred vision or eye pain Yes❑ No❑
If yes, please explain________________________________

3. Ears, Nose, Throat Decreased hearing, congestion Yes❑ No❑
If yes, please explain________________________________

4. Cardiovascular Chest pain or palpitations Yes❑ No❑
If yes, please explain________________________________

5. Respiratory Cough, shortness of breath Yes❑ No❑
If yes, please explain________________________________

6. Gastrointestinal Abdominal pain, vomiting, diarrhea Yes❑ No❑
If yes, please explain________________________________

7. Genital/ Urinary Pain urinating or difficulty urinating Yes❑ No❑
If yes, please explain________________________________

8. Musculoskeletal Arm, leg, or back pain, joint pain Yes❑ No❑
If yes, please explain________________________________

9. Skin Rash or wounds Yes❑ No❑
If yes, please explain________________________________

10. Neurological Paralysis, numbness, or seizures Yes❑ No❑
If yes, please explain________________________________

11. Endocrine Thirst, heat or cold intolerance Yes❑ No❑
If yes, please explain________________________________

12. Hematologic Bleeding or bruising Yes❑ No❑
If yes, please explain________________________________

13. Allergic/ Immune Recurrent infections Yes❑ No❑
If yes, please explain________________________________

14. Psychiatric Depression or drug abuse Yes❑ No❑
If yes, please explain________________________________

15. Other________________________________

Patient Signature ______________________________ Date__________________