

## REVIEW OF SYSTEMS

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First Name	Initial	Last Name	Date
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<b>GENERAL</b>	<b>NOW</b>	<b>PAST</b>	<b>EYES</b>	<b>NOW</b>	<b>PAST</b>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	Blurry	<input type="checkbox"/>	<input type="checkbox"/>
Fever	<input type="checkbox"/>	<input type="checkbox"/>	Double	<input type="checkbox"/>	<input type="checkbox"/>
Weakness	<input type="checkbox"/>	<input type="checkbox"/>	Pain	<input type="checkbox"/>	<input type="checkbox"/>
Weight Loss	<input type="checkbox"/>	<input type="checkbox"/>	Floaters	<input type="checkbox"/>	<input type="checkbox"/>
<b>EARS</b>	<b>NOW</b>	<b>PAST</b>	<b>NOSE</b>	<b>NOW</b>	<b>PAST</b>
Hearing Loss	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding	<input type="checkbox"/>	<input type="checkbox"/>
Earache	<input type="checkbox"/>	<input type="checkbox"/>	Loss of Smell	<input type="checkbox"/>	<input type="checkbox"/>
Discharge	<input type="checkbox"/>	<input type="checkbox"/>	Obstruction	<input type="checkbox"/>	<input type="checkbox"/>
Ringing	<input type="checkbox"/>	<input type="checkbox"/>	Sinus problem	<input type="checkbox"/>	<input type="checkbox"/>
<b>THROAT</b>	<b>NOW</b>	<b>PAST</b>	<b>HEAD</b>	<b>NOW</b>	<b>PAST</b>
Soreness	<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>
Swallowing	<input type="checkbox"/>	<input type="checkbox"/>	Injuries	<input type="checkbox"/>	<input type="checkbox"/>
Infections	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	<input type="checkbox"/>
<b>SKIN</b>	<b>NOW</b>	<b>PAST</b>	<b>MOUTH</b>	<b>NOW</b>	<b>PAST</b>
Rashes	<input type="checkbox"/>	<input type="checkbox"/>	Bad breath	<input type="checkbox"/>	<input type="checkbox"/>
Itching	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding Gums	<input type="checkbox"/>	<input type="checkbox"/>
Dryness	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Mole Changes	<input type="checkbox"/>	<input type="checkbox"/>	Dental Problem	<input type="checkbox"/>	<input type="checkbox"/>
Sores	<input type="checkbox"/>	<input type="checkbox"/>	Loss of Taste	<input type="checkbox"/>	<input type="checkbox"/>
<b>CHEST</b>	<b>NOW</b>	<b>PAST</b>	<b>BREASTS</b>	<b>NOW</b>	<b>PAST</b>
Short Breath	<input type="checkbox"/>	<input type="checkbox"/>	Lumps	<input type="checkbox"/>	<input type="checkbox"/>
Cough	<input type="checkbox"/>	<input type="checkbox"/>	Pain	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	Discharge	<input type="checkbox"/>	<input type="checkbox"/>
Wheezing	<input type="checkbox"/>	<input type="checkbox"/>			
<b>HEART</b>	<b>NOW</b>	<b>PAST</b>	<b>GASTROINT</b>	<b>NOW</b>	<b>PAST</b>
Cold Extremity	<input type="checkbox"/>	<input type="checkbox"/>	Abdominal Pain	<input type="checkbox"/>	<input type="checkbox"/>
Ankle Edema	<input type="checkbox"/>	<input type="checkbox"/>	Nausea	<input type="checkbox"/>	<input type="checkbox"/>
Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Vomiting	<input type="checkbox"/>	<input type="checkbox"/>
Varicosity	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>
Blood Clots	<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>
Palpitations	<input type="checkbox"/>	<input type="checkbox"/>	Bloody Stool	<input type="checkbox"/>	<input type="checkbox"/>
<b>GENITOURIN</b>	<b>NOW</b>	<b>PAST</b>	Black Stool	<input type="checkbox"/>	<input type="checkbox"/>
Urine Hesitancy	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice	<input type="checkbox"/>	<input type="checkbox"/>
Incontinance	<input type="checkbox"/>	<input type="checkbox"/>	Heartburn	<input type="checkbox"/>	<input type="checkbox"/>
Urgency	<input type="checkbox"/>	<input type="checkbox"/>	Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>
Frequency	<input type="checkbox"/>	<input type="checkbox"/>	Belching	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/>	Loss of Appetite	<input type="checkbox"/>	<input type="checkbox"/>
<b>WOMAN</b>	<b>NOW</b>	<b>PAST</b>	<b>MAN</b>	<b>NOW</b>	<b>PAST</b>
Painful Sex	<input type="checkbox"/>	<input type="checkbox"/>	Impotence	<input type="checkbox"/>	<input type="checkbox"/>
Discharge	<input type="checkbox"/>	<input type="checkbox"/>	Loss of Libido	<input type="checkbox"/>	<input type="checkbox"/>
Irreg Periods	<input type="checkbox"/>	<input type="checkbox"/>	Dribbling	<input type="checkbox"/>	<input type="checkbox"/>
Hot Flashes	<input type="checkbox"/>	<input type="checkbox"/>	<b>BLOOD/LYMPH</b>		
Loss of Libido	<input type="checkbox"/>	<input type="checkbox"/>	Bruising	<input type="checkbox"/>	<input type="checkbox"/>

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Spotting	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding	<input type="checkbox"/>	<input type="checkbox"/>
Heavy Flow	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>
UTI	<input type="checkbox"/>	<input type="checkbox"/>	Swollen Glands	<input type="checkbox"/>	<input type="checkbox"/>
<b>ENDOCRINE</b>	<b>NOW</b>	<b>PAST</b>	<b>MUSCULOSK</b>	<b>NOW</b>	<b>PAST</b>
Heat Intolerant	<input type="checkbox"/>	<input type="checkbox"/>	Joint Stiffness	<input type="checkbox"/>	<input type="checkbox"/>
Cold Intolerant	<input type="checkbox"/>	<input type="checkbox"/>	Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>
Weight Loss	<input type="checkbox"/>	<input type="checkbox"/>	Muscle Pain	<input type="checkbox"/>	<input type="checkbox"/>
Weight Gain	<input type="checkbox"/>	<input type="checkbox"/>	Muscle Cramps	<input type="checkbox"/>	<input type="checkbox"/>
Hair Changes	<input type="checkbox"/>	<input type="checkbox"/>	Muscle Spasms	<input type="checkbox"/>	<input type="checkbox"/>
<b>PSYCHOLOGIC</b>	<b>NOW</b>	<b>PAST</b>	<b>NEUROLOGIC</b>	<b>NOW</b>	<b>PAST</b>
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	Numbness	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	Tingling	<input type="checkbox"/>	<input type="checkbox"/>
Loss of Interest	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Phobias	<input type="checkbox"/>	<input type="checkbox"/>	Incoordination	<input type="checkbox"/>	<input type="checkbox"/>
Suicidal Ideas	<input type="checkbox"/>	<input type="checkbox"/>	Memory Loss	<input type="checkbox"/>	<input type="checkbox"/>
Drugs	<input type="checkbox"/>	<input type="checkbox"/>	Vertigo	<input type="checkbox"/>	<input type="checkbox"/>
Alcoholism	<input type="checkbox"/>	<input type="checkbox"/>	Difficult Speech	<input type="checkbox"/>	<input type="checkbox"/>
Hallucinations	<input type="checkbox"/>	<input type="checkbox"/>	Paralysis	<input type="checkbox"/>	<input type="checkbox"/>
Insomnia	<input type="checkbox"/>	<input type="checkbox"/>	Hand Tremors	<input type="checkbox"/>	<input type="checkbox"/>

### PAST MEDICAL HISTORY

Diabetes	<input type="checkbox"/>	Bladder Prob	<input type="checkbox"/>	Parasites	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	Hay Fever	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>
HIV/AIDS	<input type="checkbox"/>	Gallstones	<input type="checkbox"/>	Hypertension	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	Kidney Stones	<input type="checkbox"/>	Mental Illness	<input type="checkbox"/>
Heart Problems	<input type="checkbox"/>	Migraines	<input type="checkbox"/>	Autoimmune	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	Phlebitis	<input type="checkbox"/>
Varicose Veins	<input type="checkbox"/>	Sexual Prob	<input type="checkbox"/>	STD	<input type="checkbox"/>
Skin Problems	<input type="checkbox"/>	Kidney Infect	<input type="checkbox"/>	Ulcer	<input type="checkbox"/>