

REVIEW OF SYSTEMS

Do you now have or have you had any problems related to the following systems? Circle (Y) Yes or (N) No.
PLEASE EXPLAIN ANY YES ANSWERS IN THE SPACE PROVIDED.

<p align="center">Constitutional Symptoms</p> <table style="width:100%; border-collapse: collapse;"> <tr><td>Chills</td><td align="center">N</td><td align="center">Y</td></tr> <tr><td>Fever</td><td align="center">N</td><td align="center">Y</td></tr> <tr><td>Weight Loss</td><td align="center">N</td><td align="center">Y</td></tr> </table> <p>Other: _____</p>	Chills	N	Y	Fever	N	Y	Weight Loss	N	Y	<p align="center">Cardiovascular</p> <table style="width:100%; border-collapse: collapse;"> <tr><td>Chest Pain</td><td align="center">N</td><td align="center">Y</td></tr> <tr><td>Heart Murmur</td><td align="center">N</td><td align="center">Y</td></tr> <tr><td>Palpitations</td><td align="center">N</td><td align="center">Y</td></tr> <tr><td>Varicose Veins</td><td align="center">N</td><td align="center">Y</td></tr> </table> <p>Other: _____</p>	Chest Pain	N	Y	Heart Murmur	N	Y	Palpitations	N	Y	Varicose Veins	N	Y																		
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<p align="center">Genitourinary</p> <table style="width:100%; border-collapse: collapse;"> <tr><td>Painful Urination</td><td align="center">N</td><td align="center">Y</td></tr> <tr><td>Erectile Dysfunction</td><td align="center">N</td><td align="center">Y</td></tr> <tr><td>Blood In Urine</td><td align="center">N</td><td align="center">Y</td></tr> <tr><td>Urinary Frequency</td><td align="center">N</td><td align="center">Y</td></tr> <tr><td>Urinary Incontinence</td><td align="center">N</td><td align="center">Y</td></tr> <tr><td>Urinary Retention</td><td align="center">N</td><td align="center">Y</td></tr> </table> <p>Other: _____</p>	Painful Urination	N	Y	Erectile Dysfunction	N	Y	Blood In Urine	N	Y	Urinary Frequency	N	Y	Urinary Incontinence	N	Y	Urinary Retention	N	Y	<p align="center">Metabolic/Endocrine</p> <table style="width:100%; border-collapse: collapse;"> <tr><td>Too Cold</td><td align="center">N</td><td align="center">Y</td></tr> <tr><td>Excessive Thirst</td><td align="center">N</td><td align="center">Y</td></tr> <tr><td>Fatigue</td><td align="center">N</td><td align="center">Y</td></tr> <tr><td>Too Hot</td><td align="center">N</td><td align="center">Y</td></tr> <tr><td>Hot Flashes</td><td align="center">N</td><td align="center">Y</td></tr> </table> <p>Other: _____</p>	Too Cold	N	Y	Excessive Thirst	N	Y	Fatigue	N	Y	Too Hot	N	Y	Hot Flashes	N	Y						
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<p align="center">Musculoskeletal</p> <table style="width:100%; border-collapse: collapse;"> <tr><td>Arthritis</td><td align="center">N</td><td align="center">Y</td></tr> <tr><td>Back Pain</td><td align="center">N</td><td align="center">Y</td></tr> <tr><td>Joint Pain</td><td align="center">N</td><td align="center">Y</td></tr> <tr><td>Neck Pain</td><td align="center">N</td><td align="center">Y</td></tr> </table> <p>Other: _____</p>	Arthritis	N	Y	Back Pain	N	Y	Joint Pain	N	Y	Neck Pain	N	Y	<p align="center">Ears/Nose/Throat/Mouth</p> <table style="width:100%; border-collapse: collapse;"> <tr><td>Blurred Vision</td><td align="center">N</td><td align="center">Y</td></tr> <tr><td>Double Vision</td><td align="center">N</td><td align="center">Y</td></tr> <tr><td>Ear Infection</td><td align="center">N</td><td align="center">Y</td></tr> <tr><td>Eye Pain</td><td align="center">N</td><td align="center">Y</td></tr> <tr><td>Hearing Loss</td><td align="center">N</td><td align="center">Y</td></tr> <tr><td>Sinus Infection</td><td align="center">N</td><td align="center">Y</td></tr> <tr><td>Sore Throat</td><td align="center">N</td><td align="center">Y</td></tr> </table> <p>Other: _____</p>	Blurred Vision	N	Y	Double Vision	N	Y	Ear Infection	N	Y	Eye Pain	N	Y	Hearing Loss	N	Y	Sinus Infection	N	Y	Sore Throat	N	Y						
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<p align="center">Gastrointestinal</p> <table style="width:100%; border-collapse: collapse;"> <tr><td>Abdominal Pain</td><td align="center">N</td><td align="center">Y</td></tr> <tr><td>Blood In Stool</td><td align="center">N</td><td align="center">Y</td></tr> <tr><td>Constipation</td><td align="center">N</td><td align="center">Y</td></tr> <tr><td>Diarrhea</td><td align="center">N</td><td align="center">Y</td></tr> <tr><td>Heartburn</td><td align="center">N</td><td align="center">Y</td></tr> <tr><td>Loss Of Appetite</td><td align="center">N</td><td align="center">Y</td></tr> <tr><td>Nausea</td><td align="center">N</td><td align="center">Y</td></tr> <tr><td>Vomiting</td><td align="center">N</td><td align="center">Y</td></tr> </table> <p>Other: _____</p>	Abdominal Pain	N	Y	Blood In Stool	N	Y	Constipation	N	Y	Diarrhea	N	Y	Heartburn	N	Y	Loss Of Appetite	N	Y	Nausea	N	Y	Vomiting	N	Y	<p align="center">Reproductive</p> <table style="width:100%; border-collapse: collapse;"> <tr><td>Breast Lumps</td><td align="center">N</td><td align="center">Y</td></tr> <tr><td>Breast Pain</td><td align="center">N</td><td align="center">Y</td></tr> <tr><td>Vaginal Discharge</td><td align="center">N</td><td align="center">Y</td></tr> <tr><td>Penile Discharge</td><td align="center">N</td><td align="center">Y</td></tr> <tr><td>Sexual Dysfunction</td><td align="center">N</td><td align="center">Y</td></tr> </table> <p>Other: _____</p>	Breast Lumps	N	Y	Breast Pain	N	Y	Vaginal Discharge	N	Y	Penile Discharge	N	Y	Sexual Dysfunction	N	Y
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<p align="center">Neurological</p> <table style="width:100%; border-collapse: collapse;"> <tr><td>Difficulty Walking/Dizziness</td><td align="center">N</td><td align="center">Y</td></tr> <tr><td>Headache</td><td align="center">N</td><td align="center">Y</td></tr> <tr><td>Memory Loss</td><td align="center">N</td><td align="center">Y</td></tr> <tr><td>Seizures</td><td align="center">N</td><td align="center">Y</td></tr> <tr><td>Tremors</td><td align="center">N</td><td align="center">Y</td></tr> <tr><td>Numbness/Tingling</td><td align="center">N</td><td align="center">Y</td></tr> </table> <p>Other: _____</p>	Difficulty Walking/Dizziness	N	Y	Headache	N	Y	Memory Loss	N	Y	Seizures	N	Y	Tremors	N	Y	Numbness/Tingling	N	Y	<p align="center">Hematologic/Lymphatic</p> <table style="width:100%; border-collapse: collapse;"> <tr><td>Easy Bleeding</td><td align="center">N</td><td align="center">Y</td></tr> <tr><td>Swollen Glands</td><td align="center">N</td><td align="center">Y</td></tr> </table> <p>Other: _____</p>	Easy Bleeding	N	Y	Swollen Glands	N	Y															
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<p align="center">Respiratory</p> <table style="width:100%; border-collapse: collapse;"> <tr><td>Frequent Cough</td><td align="center">N</td><td align="center">Y</td></tr> <tr><td>Shortness Of Breath</td><td align="center">N</td><td align="center">Y</td></tr> <tr><td>Known TB Exposure</td><td align="center">N</td><td align="center">Y</td></tr> <tr><td>Wheezing</td><td align="center">N</td><td align="center">Y</td></tr> </table> <p>Other: _____</p>	Frequent Cough	N	Y	Shortness Of Breath	N	Y	Known TB Exposure	N	Y	Wheezing	N	Y	<p align="center">Integumentary</p> <table style="width:100%; border-collapse: collapse;"> <tr><td>Contact Allergy</td><td align="center">N</td><td align="center">Y</td></tr> <tr><td>Hives</td><td align="center">N</td><td align="center">Y</td></tr> <tr><td>Itching Skin</td><td align="center">N</td><td align="center">Y</td></tr> <tr><td>Rash</td><td align="center">N</td><td align="center">Y</td></tr> </table> <p>Other: _____</p>	Contact Allergy	N	Y	Hives	N	Y	Itching Skin	N	Y	Rash	N	Y															
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<p align="center">Psychiatric</p> <table style="width:100%; border-collapse: collapse;"> <tr><td>Anxiety</td><td align="center">N</td><td align="center">Y</td></tr> <tr><td>Depression</td><td align="center">N</td><td align="center">Y</td></tr> <tr><td>Insomnia</td><td align="center">N</td><td align="center">Y</td></tr> </table> <p>Other: _____</p>	Anxiety	N	Y	Depression	N	Y	Insomnia	N	Y	<p align="center">Immunologic</p> <table style="width:100%; border-collapse: collapse;"> <tr><td>Asthma</td><td align="center">N</td><td align="center">Y</td></tr> <tr><td>Food Allergies</td><td align="center">N</td><td align="center">Y</td></tr> </table> <p>Other: _____</p>	Asthma	N	Y	Food Allergies	N	Y																								
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Print Patient's Name: _____

Patient's Signature: _____