Review of Systems

Please mark each item below for each sign or symptom you presently have or previously had:

GENERAL SYMPTOMS
___ Convulsions
___ Dizziness
___ Fainting
___ Headache
___ Nervousness
___ Numbness
___ Wheezing

MUSCLES & JOINTS
___ Low Back Problems
___ Pain between Shoulders
___ Neck Problems
___ Arm Problems
___ Leg Problems
___ Swollen Joints
___ Painful Joints
___ Stiff Joints
___ Sore Muscles
___ Weak Muscles
___ Walking Problems
___ Sprains/Strains
___ Broken Bones

CARDIO-VASCULAR
___ High Blood Pressure
___ Heart Attack
___ Chest Pain
___ Irregular Heartbeat
___ Poor Circulation
___ Heart Trouble
___ Rapid Heart
___ Strokes
___ Swelling Ankles
___ Varicose Veins

Other:____________________

GASTRO-INTESTINAL
___ Belching/Gas
___ Bloating
___ Constipation
___ Diarrhea
___ Excessive Hunger
___ Excessive Thirst
___ Gall Bladder Trouble
___ Liver Trouble
___ Nausea
___ Abdominal Pain
___ Ulcer
___ Poor Appetite
___ Diabetes
___ Vomiting
___ Vomiting Blood
___ Black Stool
___ Bloody Stool
___ Weight Loss/Gain

RESPIRATORY
___ Asthma
___ Chronic Cough
___ Difficulty Breathing
___ Spitting Blood
___ Spitting Phlegm

GENITO-URINARY
___ Blood in Urine
___ Frequent Urination
___ Kidney Infection
___ Painful Urination
___ Prostate Problems
___ Loss of Bladder Control

Other:____________________

EAR/NOSE/THROAT
___ Earache
___ Ringing in Ears
___ Discharge from Ears
___ Enlarged Thyroid
___ Frequent Colds
___ Hay Fever
___ Nasal Blockage
___ Nose Bleeds
___ Pain Behind Eyes
___ Persistent Cough
___ Blurry Vision
___ Sinus Problems
___ Tonsillitis
___ Sore Throats
___ Hoarseness

SKIN OR ALLERGIES
___ Boils
___ Bruising Easily
___ Dryness
___ Eczema/Rash/Dermatitis
___ Hives
___ Itching
___ Sensitive Skin
___ Allergy __________________

FOR WOMEN ONLY
___ Birth Control __________
___ Hormone Replacement
___ Cramps/Backaches
___ Irregular Cycle
___ Painful Periods
___ Breast Pain
Pregnant at this Time Y/N

Other:____________________

I hereby certify that the statements and answers given on this form are accurate to the best of knowledge and understand it is my responsibility to inform this office of any changes in my health. I agree to allow this office to examine me for further evaluation.

Patient Signature____ Date___________________