Review of Systems

Do you currently, or have you ever had, any problems in the following areas?
If yes, please explain and list medications.

SYSTEM	NO	YES	EXPLAIN/LIST MEDICATIONS
CONSTITUTIONAL (fever, weight loss, gain)	____	____	_____
INTEGUMENTARY (skin)	____	____	_____
NEUROLOGICAL			
Headaches/migraines	____	____	_____
Seizures	____	____	_____
EYES			
Loss of Vision	____	____	_____
Blurred Vision	____	____	_____
Distorted vision/halos	____	____	_____
Loss of side vision	____	____	_____
Double vision	____	____	_____
Dryness, sandy or gritty sensation	____	____	_____
Mucous discharge	____	____	_____
Itching, burning	____	____	_____
Excess tearing/watering	____	____	_____
Glare/light sensitivity	____	____	_____
Eye pain or soreness	____	____	_____
Chronic infection of eye or eyelid	____	____	_____
Sties or chalazion	____	____	_____
Flashes or floaters	____	____	_____
EARS, NOSE, MOUTH, THROAT			
Allergies/hay fever	____	____	_____
Sinus Congestion	____	____	_____
Runny nose	____	____	_____
Chronic cough	____	____	_____
Dry throat, mouth	____	____	_____
RESPIRATORY			
Asthma	____	____	_____
Chronic bronchitis	____	____	_____
Emphysema	____	____	_____
VASCULAR/CARDIOVASCULAR			
Diabetes	____	____	_____
Heart pain	____	____	_____
High blood pressure	____	____	_____
High Cholesterol	____	____	_____
GASTROINTESTINAL			
Diarrhea/constipation	____	____	_____
GENINTOURINARY			
Genitals/kidney/bladder	____	____	_____
BONES/JOINTS/MUSCLES			
Rheumatoid arthritis	____	____	_____
Muscle pain/joint pain	____	____	_____
LYMPHATIC/HEMATOLOGIC			
Anemia/bleeding problems	____	____	_____
ENDOCRINE			
Thyroid/other glands	____	____	_____
ALERGIC/IMMUNOLOGI	____	____	_____

Do you have any other concerns?_____

Home phone number:_____Work Phone number: _____ Cell phone number_____

Patient Signature:_____ Date:_____ Dr. Initials _____