

NAME: _____

BIRTH DATE: ____/____/____

REVIEW OF SYSTEMS**Please Check (X) If Any Of The Following Applies To You NOW.**

CONSTITUTIONAL	NOTES	SKIN	NOTES
Weight Loss	<input type="checkbox"/>	Rashes	<input type="checkbox"/>
Weight Gain	<input type="checkbox"/>	Changes to Lesions or Moles	<input type="checkbox"/>
Fever	<input type="checkbox"/>	Acne	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>		
Chills	<input type="checkbox"/>	NEUROLOGICAL	
Decreased Appetite	<input type="checkbox"/>	Muscular Weakness	<input type="checkbox"/>
	<input type="checkbox"/>	Numbness or Tingling	<input type="checkbox"/>
EYES		Seizures	<input type="checkbox"/>
Vision changes	<input type="checkbox"/>		<input type="checkbox"/>
	<input type="checkbox"/>	MUSCULOSKELETAL	
HENT		Joint Pain or Swelling	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	Muscle Pain	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>		<input type="checkbox"/>
Sore Throat	<input type="checkbox"/>	ENDOCRINE	
Sinus Congestion	<input type="checkbox"/>	Loss of Hair	<input type="checkbox"/>
Lightheadedness	<input type="checkbox"/>	Difficulty Tolerating Cold	<input type="checkbox"/>
Decreased hearing	<input type="checkbox"/>	Difficulty Tolerating Heat	<input type="checkbox"/>
	<input type="checkbox"/>	Excessive Thirst	<input type="checkbox"/>
	<input type="checkbox"/>	Excessive Urination	<input type="checkbox"/>
BREAST			<input type="checkbox"/>
Lumps	<input type="checkbox"/>	PSYCHIATRIC	
Tenderness	<input type="checkbox"/>	Anxiety	<input type="checkbox"/>
Swelling	<input type="checkbox"/>	Depression	<input type="checkbox"/>
Discharge	<input type="checkbox"/>	Sexual Abuse	<input type="checkbox"/>
Pain in Breast	<input type="checkbox"/>		<input type="checkbox"/>
	<input type="checkbox"/>	HEMATOLOGIC/ LYMPHATIC	
CARDIOVASCULAR		Enlarged lymph nodes	<input type="checkbox"/>
Chest Pain	<input type="checkbox"/>	Tender lymph nodes	<input type="checkbox"/>
Shortness of Breath w/ Exertion	<input type="checkbox"/>		<input type="checkbox"/>
Rapid Heart Rate	<input type="checkbox"/>	ALLERGIC/IMMUNOLOGIC	<input type="checkbox"/>
Fainting	<input type="checkbox"/>	Eczema	<input type="checkbox"/>
Swelling of legs	<input type="checkbox"/>	Seasonal Allergies	<input type="checkbox"/>
Varicose veins	<input type="checkbox"/>		<input type="checkbox"/>
	<input type="checkbox"/>	OTHER	
RESPIRATORY		1.	<input type="checkbox"/>
Wheezing	<input type="checkbox"/>	2.	<input type="checkbox"/>
Cough	<input type="checkbox"/>	3.	<input type="checkbox"/>
Shortness of breath	<input type="checkbox"/>		
	<input type="checkbox"/>		
GASTROINTESTINAL			
Nausea	<input type="checkbox"/>		
Vomiting	<input type="checkbox"/>		
Constipation	<input type="checkbox"/>		
Abdominal Pain	<input type="checkbox"/>		
	<input type="checkbox"/>		
GENTOURNARY			
Urgency of urination	<input type="checkbox"/>		
Frequency of urination	<input type="checkbox"/>		
Pain with urination	<input type="checkbox"/>		
Losing urine	<input type="checkbox"/>		
Vaginal Irritation	<input type="checkbox"/>		
Vaginal Discharge	<input type="checkbox"/>		
Vaginal Itching	<input type="checkbox"/>		
Vaginal Odor	<input type="checkbox"/>		
Genital Sores	<input type="checkbox"/>		