



REVIEW OF SYSTEMS

Cardiovascular:

	<u>Present</u>	<u>Past</u>	<u>No</u>
Poor circulation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Aortic Aneurysm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vascular disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart attack	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chest pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Jaw pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Irregular heartbeat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Swelling of legs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> None of the above			

Genitourinary:

	<u>Present</u>	<u>Past</u>	<u>No</u>
Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lower side pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Burning urination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Frequent urination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood and urine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney stone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> None of the above			

Hematologic/Lymphatic:

	<u>Present</u>	<u>Past</u>	<u>No</u>
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood clots	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Easy bruising	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Easy bleeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fever/Chills/Sweats	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> None of the above			

Respiratory:

	<u>Present</u>	<u>Past</u>	<u>No</u>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cold/Flu	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cough/Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> None of the above			

Ear/Nose/Throat:

	<u>Present</u>	<u>Past</u>	<u>No</u>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hearing loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sinus infection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nosebleed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sore throat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty swallowing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding gums	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> None of the above			

Eyes:

	<u>Present</u>	<u>Past</u>	<u>No</u>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Double vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blurred vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> None of the above			

Integumentary:

	<u>Present</u>	<u>Past</u>	<u>No</u>
Skin ulcers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Skin disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eczema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Psoriasis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rashes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> None of the above			

Allergic/Immunologic:

	<u>Present</u>	<u>Past</u>	<u>No</u>
Hives	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Immune disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Allergy shot	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cortisone use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> None of the above			

Gastrointestinal:

	<u>Present</u>	<u>Past</u>	<u>No</u>
Gallbladder problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bowel problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Liver problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nausea/Vomiting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bloody stools	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Poor appetite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> None of the above			

Musculoskeletal:

	<u>Present</u>	<u>Past</u>	<u>No</u>
Gout	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Joint stiffness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Muscle weakness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Broken bones	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Joints replace	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> None of the above			

Neurological:

	<u>Present</u>	<u>Past</u>	<u>No</u>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Head injury	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Brain aneurysm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Numbness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Severe headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pinched nerves	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Parkinson's disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Carpal tunnel	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Standing/Balance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> None of the above			

Endocrine:

	<u>Present</u>	<u>Past</u>	<u>No</u>
Thyroid disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hair loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Menopausal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Menstrual problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> None of the above			

Psychiatric:

	<u>Present</u>	<u>Past</u>	<u>No</u>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Unusual stress	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> None of the above			

Constitutional:

	<u>Present</u>	<u>Past</u>	<u>No</u>
Weight loss/gain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Energy level problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty sleeping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> None of the above			