

Name:

Date:

Account #:

REVIEW OF SYSTEMS

Please check **Y**=Yes if condition applies to you

CONSTITUTIONAL		
Y	N	
<input type="checkbox"/>	<input type="checkbox"/>	weakness
<input type="checkbox"/>	<input type="checkbox"/>	fatigue
<input type="checkbox"/>	<input type="checkbox"/>	fever
<input type="checkbox"/>	<input type="checkbox"/>	chills
<input type="checkbox"/>	<input type="checkbox"/>	night sweats
<input type="checkbox"/>	<input type="checkbox"/>	fainting
<input type="checkbox"/>	<input type="checkbox"/>	nervousness
<input type="checkbox"/>	<input type="checkbox"/>	concentration loss
<input type="checkbox"/>	<input type="checkbox"/>	dizzy spells
<input type="checkbox"/>	<input type="checkbox"/>	irritability
<input type="checkbox"/>	<input type="checkbox"/>	depression
<input type="checkbox"/>	<input type="checkbox"/>	memory loss
<input type="checkbox"/>	<input type="checkbox"/>	loss of sleep
<input type="checkbox"/>	<input type="checkbox"/>	headache
<input type="checkbox"/>	<input type="checkbox"/>	apprehensions

MUSCULOSKELETAL		
Y	N	
<input type="checkbox"/>	<input type="checkbox"/>	muscle pain
<input type="checkbox"/>	<input type="checkbox"/>	muscle weakness
<input type="checkbox"/>	<input type="checkbox"/>	muscle cramps
<input type="checkbox"/>	<input type="checkbox"/>	joint stiffness
<input type="checkbox"/>	<input type="checkbox"/>	joint tenderness
<input type="checkbox"/>	<input type="checkbox"/>	spinal curvature
<input type="checkbox"/>	<input type="checkbox"/>	back pain
<input type="checkbox"/>	<input type="checkbox"/>	hot joints
<input type="checkbox"/>	<input type="checkbox"/>	joint swelling
<input type="checkbox"/>	<input type="checkbox"/>	stiff neck
<input type="checkbox"/>	<input type="checkbox"/>	soreness
<input type="checkbox"/>	<input type="checkbox"/>	lumps
<input type="checkbox"/>	<input type="checkbox"/>	masses

NEUROLOGICAL		
Y	N	
<input type="checkbox"/>	<input type="checkbox"/>	seizures
<input type="checkbox"/>	<input type="checkbox"/>	vertigo
<input type="checkbox"/>	<input type="checkbox"/>	dizziness
<input type="checkbox"/>	<input type="checkbox"/>	tremors
<input type="checkbox"/>	<input type="checkbox"/>	loss of sensations
<input type="checkbox"/>	<input type="checkbox"/>	loss of coordination
<input type="checkbox"/>	<input type="checkbox"/>	weak grip
<input type="checkbox"/>	<input type="checkbox"/>	paralysis
<input type="checkbox"/>	<input type="checkbox"/>	difficulty of speech
<input type="checkbox"/>	<input type="checkbox"/>	tingling
<input type="checkbox"/>	<input type="checkbox"/>	numbness
<input type="checkbox"/>	<input type="checkbox"/>	memory loss

ALLERGIES		
No known allergies		
Y	N	
<input type="checkbox"/>	<input type="checkbox"/>	animal dander
<input type="checkbox"/>	<input type="checkbox"/>	latex
<input type="checkbox"/>	<input type="checkbox"/>	food allergies
<input type="checkbox"/>	<input type="checkbox"/>	penicillin
<input type="checkbox"/>	<input type="checkbox"/>	pollen
<input type="checkbox"/>	<input type="checkbox"/>	second hand smoke
<input type="checkbox"/>	<input type="checkbox"/>	grasses
<input type="checkbox"/>	<input type="checkbox"/>	sulfa drugs
<input type="checkbox"/>	<input type="checkbox"/>	dairy products
<input type="checkbox"/>	<input type="checkbox"/>	perfumes
<input type="checkbox"/>	<input type="checkbox"/>	hay

FAMILY HISTORY

	MOTHER		FATHER		SIBLINGS	
Cancer, including leukemia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Tuberculosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Heart trouble	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
High blood pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Stroke	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Epilepsy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Bleeding disorder	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Allergies	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Jaundice	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Hepatitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Migraine headaches	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Alcoholism	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Emphysema	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Stomach ulcer	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Kidney disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Glaucoma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Mental illness	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Suicide	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Birth defects	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Who in your family is still living?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Who has died?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Who is in good health?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No

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