

REVIEW OF SYSTEMS

Please mark YES or NO if you have had the following symptoms in the last 6 months.

Y N General

<input type="checkbox"/>	<input type="checkbox"/>	Fatigue or weakness
<input type="checkbox"/>	<input type="checkbox"/>	Decreased appetite
<input type="checkbox"/>	<input type="checkbox"/>	Fever or night sweats
<input type="checkbox"/>	<input type="checkbox"/>	Recent weight change

Y N Genitourinary

<input type="checkbox"/>	<input type="checkbox"/>	Blood in Urine
<input type="checkbox"/>	<input type="checkbox"/>	Kidney stones
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty with urination
<input type="checkbox"/>	<input type="checkbox"/>	Menstrual abnormalities

Y N Hematology

<input type="checkbox"/>	<input type="checkbox"/>	Bleeding disorder
<input type="checkbox"/>	<input type="checkbox"/>	Easy bruising
<input type="checkbox"/>	<input type="checkbox"/>	Past blood transfusion
<input type="checkbox"/>	<input type="checkbox"/>	Swollen glands

Y N Ear, Nose, Throat/Respiratory

<input type="checkbox"/>	<input type="checkbox"/>	Cough
<input type="checkbox"/>	<input type="checkbox"/>	Hearing loss
<input type="checkbox"/>	<input type="checkbox"/>	Nose bleeds
<input type="checkbox"/>	<input type="checkbox"/>	Sore throat
<input type="checkbox"/>	<input type="checkbox"/>	Hoarseness

Y N Cardiology

<input type="checkbox"/>	<input type="checkbox"/>	Chest pain
<input type="checkbox"/>	<input type="checkbox"/>	Dizziness
<input type="checkbox"/>	<input type="checkbox"/>	Palpitations
<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath
<input type="checkbox"/>	<input type="checkbox"/>	Ankle swelling

Y N Gastroenterology

<input type="checkbox"/>	<input type="checkbox"/>	Heartburn
<input type="checkbox"/>	<input type="checkbox"/>	Blood in stool
<input type="checkbox"/>	<input type="checkbox"/>	Trouble swallowing
<input type="checkbox"/>	<input type="checkbox"/>	Abdominal pain

Y N Eyes

<input type="checkbox"/>	<input type="checkbox"/>	Blurred vision
<input type="checkbox"/>	<input type="checkbox"/>	Eye disease

Y N Psychiatry

<input type="checkbox"/>	<input type="checkbox"/>	Anxiety
<input type="checkbox"/>	<input type="checkbox"/>	Depression
<input type="checkbox"/>	<input type="checkbox"/>	Memory or sleep disturbances

Y N Neurology

<input type="checkbox"/>	<input type="checkbox"/>	Headaches
<input type="checkbox"/>	<input type="checkbox"/>	Dizziness
<input type="checkbox"/>	<input type="checkbox"/>	Seizures

Y N Musculoskeletal

<input type="checkbox"/>	<input type="checkbox"/>	Joint pain, swelling or stiffness
<input type="checkbox"/>	<input type="checkbox"/>	Ankle swelling

Y N Dermatology

<input type="checkbox"/>	<input type="checkbox"/>	Itching or rash
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Medications (Please Print)

Medications	Dosage (mg)	Times Daily	Reason/Condition	Prescribing Doctor

List Allergies: _____

Name (Print): _____

Signature: _____

Date: _____