



**REVIEW OF SYSTEMS: Please indicate any personal history below:**

**MUSCULOSKELETAL**

Joint Pain	No	Yes
Joint Stiffness/Swelling	No	Yes
Weakness of Muscles/Joints	No	Yes
Muscle Pain/Cramps	No	Yes
Back Pain	No	Yes
Cold Extremities	No	Yes
Difficulty in Walking	No	Yes

**CONSTITUTIONAL SYMPTOMS**

Bad General Health Lately	No	Yes
Recent Weight Change	No	Yes
Fever	No	Yes
Fatigue	No	Yes
Headaches	No	Yes
	No	Yes

**NEUROLOGICAL**

Numbness or Tingling	No	Yes
Tremors	No	Yes
Paralysis	No	Yes
Lightheaded/Dizzy	No	Yes

**HEMATOLOGIC (Blood Disorders)**

Cuts Slow to Heal	No	Yes
Tendency to Bleed/Bruise	No	Yes
Anemia	No	Yes
Enlarged Glands	No	Yes

**GASTROINTESTINAL (Stomach)**

Loss of Appetite	No	Yes
Nausea or Vomiting	No	Yes
Frequent Diarrhea	No	Yes
Constipation	No	Yes
Rectal Blood	No	Yes
Abdominal Pain	No	Yes

**GENITOURINARY**

Frequent Urination	No	Yes
Burning/Pain Urinating	No	Yes
Blood in Urine	No	Yes
Incontinence/Dribbling	No	Yes

**INTEGUMENTARY (Skin/Breast)**

Rash or Itching	No	Yes
Changes in Skin Color	No	Yes
Varicose Veins	No	Yes

**CARDIOVASCULAR (Heart)**

Chest Pain	No	Yes
Palpitation	No	Yes
Short of Breath Walking	No	Yes
Swelling of Hands/Feet	No	Yes

**PSYCHIATRIC**

Memory Loss	No	Yes
Nervousness	No	Yes
Depression	No	Yes
Insomnia	No	Yes

**RESPIRATORY (Lungs/Breathing)**

Spitting up Blood	No	Yes
Short of Breath	No	Yes
Wheezing	No	Yes
Chronic Cough	No	Yes

**EYES/EARS/MOUTH**

Eye Disease or Injury	No	Yes
Wear Contact Lens/Glasses	No	Yes
Hearing Aids	No	Yes
Dentures	No	Yes

To the best of my knowledge, the questions on this form have been answered accurately. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor of any changes in my medical status. I also authorize the medical staff to perform the necessary services I may need.

\_\_\_\_\_  
Patient's Name - Please Print

\_\_\_\_\_  
Signature of Patient or Parent of Minor

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date of Birth