REVIEW OF SYSTEMS

Do you have or have you ever had any of the following: PLEASE CHECK ALL THAT APPLY

CARDIOVASCULAR

_____Heart Murmur _____Chest pain _____High Blood Pressure _____High Cholesterol

_____Leg Pain on Walking _____Varicose veins _____Stent/Implant _____Pace Maker

ENDOCRINE

_____Hypothyroidism _____Hyperthyroidism _____Diabetes

EYES/EARS/NOSE/THROAT

_____Eye Problems _____Hearing Loss _____Speech Difficulty

GASTROINTESTINAL

_____Stomach Ulcers _____Acid Reflux _____ Liver Problems _____Excessive Thirst/Hunger

GENITOURINARY

_____Kidney Problems _____Incontinence

HEMATOLOGIC

_____Take Coumadin/Blood Thinners _____Take Aspirin

_____Bleeding Disorder _____History of Blood Clots

INTEGUMENTARY

_____Deformed Nails _____Skin Disorders _____Ulcerations ___Cancer—TYPE _____

MUSCULOSKELETAL

_____Arthritis _____Bursitis _____Sprains

_____Muscle Pain _____Fractures

NERVOUS

_____Stroke _____Seizures _____Parkinson's Disorder _____Anxiety Attacks

_____Paralysis _____Numbness _____Dizziness _____Dementia

RESPIRATORY

_____Breathing Difficulty _____Asthma _____Emphysema _____COPD

Other not listed_____

Patient Name _____Date_____