

Review of Systems Checklist

Are you <i>currently</i> experiencing any of these symptoms (Check all that apply)?		
<p>Respiratory</p> <p><input type="checkbox"/> Spitting up blood</p> <p><input type="checkbox"/> Shortness of breath</p> <p><input type="checkbox"/> Asthma or wheezing</p> <p><input type="checkbox"/> Frequent coughing</p> <p><input type="checkbox"/> None in this category</p>	<p>Women Only:</p> <p><input type="checkbox"/> Irregular periods</p> <p><input type="checkbox"/> Painful periods</p> <p><input type="checkbox"/> Vaginal discharge</p> <p><input type="checkbox"/> None in this category</p> <p><input type="checkbox"/> Date of last menstrual period: _____</p>	<p>Eyes and vision</p> <p><input type="checkbox"/> Wear glasses/contact lenses</p> <p><input type="checkbox"/> Blurred or double vision</p> <p><input type="checkbox"/> Glaucoma</p> <p><input type="checkbox"/> Eye disease or injury</p> <p><input type="checkbox"/> None in this category</p>
<p>Gastrointestinal</p> <p><input type="checkbox"/> Stomach pain</p> <p><input type="checkbox"/> Blood in stool</p> <p><input type="checkbox"/> Change in bowel movements</p> <p><input type="checkbox"/> Nausea or vomiting</p> <p><input type="checkbox"/> Frequent diarrhea</p> <p><input type="checkbox"/> Constipation</p> <p><input type="checkbox"/> Painful bowel movements</p> <p><input type="checkbox"/> Loss of appetite</p> <p><input type="checkbox"/> None in this category</p>	<p>Neurological</p> <p><input type="checkbox"/> Frequent or recurrent headaches</p> <p><input type="checkbox"/> Light headed or dizzy</p> <p><input type="checkbox"/> Convulsions or seizures</p> <p><input type="checkbox"/> Numbness or tingling sensations</p> <p><input type="checkbox"/> Tremors</p> <p><input type="checkbox"/> Stroke</p> <p><input type="checkbox"/> Have you ever had a head injury?</p> <p><input type="checkbox"/> Have you ever been in a auto accident?</p> <p><input type="checkbox"/> None in this category</p>	<p>Endocrine</p> <p><input type="checkbox"/> Thyroid problems</p> <p><input type="checkbox"/> Diabetes</p> <p><input type="checkbox"/> Excessive thirst or urination</p> <p><input type="checkbox"/> Cold extremities</p> <p><input type="checkbox"/> Heat or cold intolerance</p> <p><input type="checkbox"/> Change in hat or glove size</p> <p><input type="checkbox"/> Dry skin</p> <p><input type="checkbox"/> Glandular or hormone problem</p> <p><input type="checkbox"/> None in this category</p>
<p>Skin and breasts</p> <p><input type="checkbox"/> Rash or itching</p> <p><input type="checkbox"/> Change in skin color</p> <p><input type="checkbox"/> Change in hair or nails</p> <p><input type="checkbox"/> Nonhealing sores</p> <p><input type="checkbox"/> Change in appearance of a mole</p> <p><input type="checkbox"/> Breast pain</p> <p><input type="checkbox"/> Breast lump</p> <p><input type="checkbox"/> Breast discharge</p> <p><input type="checkbox"/> None in this category</p>	<p>Genitourinary</p> <p><input type="checkbox"/> Sexual difficulty</p> <p><input type="checkbox"/> Kidney stones</p> <p><input type="checkbox"/> Burning or painful urination</p> <p><input type="checkbox"/> Blood in urine</p> <p><input type="checkbox"/> Change in force or strain with urination</p> <p><input type="checkbox"/> Incontinence or dribbling</p> <p><input type="checkbox"/> Frequent urination</p> <p><input type="checkbox"/> None in this category</p>	<p>Musculoskeletal</p> <p><input type="checkbox"/> Joint stiffness or swelling</p> <p><input type="checkbox"/> Weakness of muscles/joints</p> <p><input type="checkbox"/> Muscle pain or cramps</p> <p><input type="checkbox"/> Muscle weakness</p> <p><input type="checkbox"/> Neck pain</p> <p><input type="checkbox"/> Upper or mid back pain</p> <p><input type="checkbox"/> Low back pain</p> <p><input type="checkbox"/> Joint pain</p> <p><input type="checkbox"/> Difficulty in walking</p> <p><input type="checkbox"/> None in this category</p>
<p>Mind/Stress</p> <p><input type="checkbox"/> Nervousness</p> <p><input type="checkbox"/> Depression</p> <p><input type="checkbox"/> Sleep problems</p> <p><input type="checkbox"/> Memory loss or confusion</p> <p><input type="checkbox"/> None in this category</p>	<p>Hematologic/Lymphatic</p> <p><input type="checkbox"/> Swollen glands</p> <p><input type="checkbox"/> Easily bruise or bleed</p> <p><input type="checkbox"/> Amemia</p> <p><input type="checkbox"/> Phlebitis</p> <p><input type="checkbox"/> Transfusion</p> <p><input type="checkbox"/> Slow to heal after cuts</p> <p><input type="checkbox"/> None in this category</p>	<p>Ears, nose, throat</p> <p><input type="checkbox"/> Bleeding gums</p> <p><input type="checkbox"/> Bad breath or bad taste</p> <p><input type="checkbox"/> Sore throat or voice change</p> <p><input type="checkbox"/> Swollen glands in neck</p> <p><input type="checkbox"/> Mouth sores</p> <p><input type="checkbox"/> Ringing in the ears</p> <p><input type="checkbox"/> Earaches or drainage</p> <p><input type="checkbox"/> Sinus problems</p> <p><input type="checkbox"/> Nose bleeds</p> <p><input type="checkbox"/> Hearing loss</p> <p><input type="checkbox"/> None in this category</p>
<p>Heart and Cardiovascular</p> <p><input type="checkbox"/> Chest pains</p> <p><input type="checkbox"/> Sudden heartbeat changes</p> <p><input type="checkbox"/> Swelling of feet, ankles, hands</p> <p><input type="checkbox"/> Heart trouble</p> <p><input type="checkbox"/> None in this category</p>	<p>General (constitutional)</p> <p><input type="checkbox"/> Recent weight change</p> <p><input type="checkbox"/> Fever</p> <p><input type="checkbox"/> Fatigue</p> <p><input type="checkbox"/> None in this category</p>	
Medical & Family History		
Please list any past surgeries or hospitalizations:		
Please list any prescription medications you currently take:		
Do you have any allergies (environmental, food, medications, latex, other):		
Is there a family history of cancer or other disease? If yes, please list:		