

Review of systems: Please indicate any personal history below

<u>Constitutional/ General</u>		<u>Musculoskeletal</u>		<u>Allergic/Immunologic</u>	
Fever.....	Yes No	Broken Bones.....	Yes No	Food Allergies.....	Yes No
Weight loss.....	Yes No	If yes, List: _____		Inhalant(Nasal Allergies).....	Yes No
Active.....	Yes No	Arms or Leg Weakness..	Yes No	If yes, have you been treated?.	Yes No
Good health.....	Yes No	Back Pain.....	Yes No	Immunologic Disorder.....	Yes No
Excessive Fatigue.....	Yes No	Arm or Leg Pain.....	Yes No		
		Joint Pain or Swelling.....	Yes No	<u>Neurological</u>	
		Arthritis.....	Yes No	Fainting Spells/Black outs.....	Yes No
<u>Eyes</u>				Seizures.....	Yes No
Wear Glasses.....	Yes No	<u>Integumentary</u>		Problems w/Memory.....	Yes No
Cataracts.....	Yes No	Skin Disease.....	Yes No	Disorientation.....	Yes No
Glaucoma.....	Yes No	Skin Cancer.....	Yes No	Difficulty to concentrate.....	Yes No
Macular degeneration.....	Yes No			Facial Weakness.....	Yes No
Retinal detachment.....	Yes No	<u>Gastrointestinal</u>		Poor Coordination in Arms...	
Double or blurred Vision.....	Yes No	Indigestion/Pain w/eating	Yes No	or Legs.....	Yes No
<u>Ear, Nose, Throat and Mouth</u>		Nausea.....	Yes No		
Hearing loss.....	Yes No	Vomiting.....	Yes No		
If yes, circle on e of the following:		Liver Disease.....	Yes No		
Left / Right / Both sides		Jaundice.....	Yes No		
Ringing in the ears.....	Yes No	Abdominal Pain.....	Yes No		
If yes, circle the following which applies:		Ulcers ir Gastritis.....	Yes No		
Left / Right / Both sides/		Colon Cancer.....	Yes No		
constant / Intermittent		Heartburn.....	Yes No		
Wear Hearing Aids.....	Yes No	Reflux.....	Yes No		
If yes, circle all that apply:					
Spinning / Unsteadiness / Off balance/		<u>Genitoruinary</u>			
Lighttheadedness		Urinary Tract Infections...	Yes No		
Exposure to Loud Noise.....	Yes No	Blood in your urine.....	Yes No		
Nose Bleeds.....	Yes No	Incontinece.....	Yes No		
Nasal Congestion.....	Yes No	Prostate Cancer(Males)..	Yes No		
Inability to smell.....	Yes No	Endometriosis(Females)	Yes No		
Sinus Problems.....	Yes No	Uterine/Cervical Cancer..	Yes No		
Sinus Headaches.....	Yes No				
Sore throats.....	Yes No	<u>Hematologic/Lymphatic</u>			
Post nasal drainage.....	Yes No	Anemia.....	Yes No		
Hoarseness.....	Yes No	Hemophilia.....	Yes No		
Difficulty swallowing.....	Yes No	Persistent Swollen Glands	Yes No		
		Swollen Lymph Nodes...	Yes No		
<u>Respiratory</u>		Blood transfusion.....	Yes No		
Chronic Cough.....	Yes No	If yes, when? _____			
Emphysema.....	Yes No				
Asthma.....	Yes No	<u>Psychiatric</u>			
Shortness of Breath.....	Yes No	Anxiety.....	Yes No		
Bronchitis.....	Yes No	Depression.....	Yes No		
Pneumonia.....	Yes No	Other Psychiatric Disorder?	Yes No		
Lung Cancer.....	Yes No	If yes, please describe: _____			
Blood Sputum.....	Yes No				
		<u>Endocrine</u>			
<u>Cardiovascular</u>		Increased Appetite.....	Yes No		
Chest Pain or Angina.....	Yes No	Excessive thirst/urination	Yes No		
Irregular Pulse.....	Yes No	Hormone Problems.....	Yes No		
High Blood Pressure?.....	Yes No	Diabetes.....	Yes No		
High Cholesterol.....	Yes No	Throid Disorder.....	Yes No		
Swelling in Feets or Hands.....	Yes No				