REVIEW OF SYSTEMS

Name:
Date of Appointment:

In the last **12 months**, have you had any of the following:

	Yes	No
GENERAL		
Fevers		
Chills		
Unexplained weight change		
Enlarged lymph nodes		
EYES		
Itchy watery eyes		
Red eyes		
Blurry vision		
EAR/NOSE/THROAT		
Ear popping		
Difficulty hearing		
Post-nasal drip		
Sinus pain/pressure		
CARDIOVASCULAR		
Heart palpitations		
Abnormal heart rhythm		
Chest pain		
RESPIRATORY		
Shortness of breath		
Chronic cough		
Wheezing		
Chest tightness		
GASTROINTESTINAL		
Heartburn/reflux		
Nausea/vomiting		
Diarrhea		

	Yes	No
BONES/JOINTS		
Painful joints		
Back pain		
SKIN		
Eczema		
Dry skin		
Sensitive skin		
Hives		
Rashes		
GENITOURINARY		
Frequent urination		
Pain with urination		
Abnormal menses (women)		
ENDOCRINE		
Heat intolerance		
Cold intolerance		
Excess thirst		
NEUROLOGICAL		
Fainting spells		
Dizziness		
Seizures		
PSYCHOLOGICAL		
Increased stress		
Depression		
Anxiety		
OTHER		

Reviewed by: **Date:**