

Name \_\_\_\_\_ Date \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

**Review of Systems** Do you currently, or have you ever had, any problems in the following areas:

	Yes	No
<b>Eyes</b>		
Itching	<input type="checkbox"/>	<input type="checkbox"/>
Diplopia	<input type="checkbox"/>	<input type="checkbox"/>
Burning	<input type="checkbox"/>	<input type="checkbox"/>
Mattering	<input type="checkbox"/>	<input type="checkbox"/>
Loss of Vision	<input type="checkbox"/>	<input type="checkbox"/>
Photophobia	<input type="checkbox"/>	<input type="checkbox"/>
Red	<input type="checkbox"/>	<input type="checkbox"/>
Floaters	<input type="checkbox"/>	<input type="checkbox"/>
Loss of Sharpness	<input type="checkbox"/>	<input type="checkbox"/>
Flashes	<input type="checkbox"/>	<input type="checkbox"/>
Tearing	<input type="checkbox"/>	<input type="checkbox"/>
Other _____		

<b>Constitutional</b>		
Developmental Disorders	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue Syndrome	<input type="checkbox"/>	<input type="checkbox"/>
Other _____		

<b>Ear, Nose, Mouth, Throat</b>		
Sinusitis	<input type="checkbox"/>	<input type="checkbox"/>
Dry Mouth	<input type="checkbox"/>	<input type="checkbox"/>
Hearing Loss	<input type="checkbox"/>	<input type="checkbox"/>
Laryngitis	<input type="checkbox"/>	<input type="checkbox"/>
Other _____		

<b>Neurological</b>		
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
Multiple Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Tumor	<input type="checkbox"/>	<input type="checkbox"/>
Cerebral Palsy	<input type="checkbox"/>	<input type="checkbox"/>
Stroke/CVA	<input type="checkbox"/>	<input type="checkbox"/>
Migraine	<input type="checkbox"/>	<input type="checkbox"/>
Other _____		

<b>Psychiatric</b>		
Depression	<input type="checkbox"/>	<input type="checkbox"/>
Bipolar	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>
Attention Deficit	<input type="checkbox"/>	<input type="checkbox"/>
Other _____		

<b>Vascular/Cardiovascular</b>		
Vascular Disease	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Congestive Heart Failure	<input type="checkbox"/>	<input type="checkbox"/>
Other _____		

<b>Respiratory</b>		
Cigarette Smoker	<input type="checkbox"/>	<input type="checkbox"/>
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>
COPD	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>

	Yes	No
<b>Respiratory (continued)</b>		
Sleep Apnea	<input type="checkbox"/>	<input type="checkbox"/>
Other _____		

<b>Gastrointestinal</b>		
Celiac Disease	<input type="checkbox"/>	<input type="checkbox"/>
Crohn's Disease	<input type="checkbox"/>	<input type="checkbox"/>
Ulcer	<input type="checkbox"/>	<input type="checkbox"/>
Colitis	<input type="checkbox"/>	<input type="checkbox"/>
Acid Reflux	<input type="checkbox"/>	<input type="checkbox"/>
Other _____		

<b>Genitourinary</b>		
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>
STD - Herpetic/Chlamydia	<input type="checkbox"/>	<input type="checkbox"/>
Prostate Disease/Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Pregnant/Nursing	<input type="checkbox"/>	<input type="checkbox"/>
Other _____		

<b>Musculoskeletal</b>		
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Ankylosing Spondylitis	<input type="checkbox"/>	<input type="checkbox"/>
Fibromyalgia	<input type="checkbox"/>	<input type="checkbox"/>
Muscular Dystrophy	<input type="checkbox"/>	<input type="checkbox"/>
Osteoarthritis	<input type="checkbox"/>	<input type="checkbox"/>
Gout	<input type="checkbox"/>	<input type="checkbox"/>
Other _____		

<b>Integumentary</b>		
Herpes Simplex/Cold Sores	<input type="checkbox"/>	<input type="checkbox"/>
Herpes Zoster/Shingles	<input type="checkbox"/>	<input type="checkbox"/>
Rosacea	<input type="checkbox"/>	<input type="checkbox"/>
Psoriasis	<input type="checkbox"/>	<input type="checkbox"/>
Eczema	<input type="checkbox"/>	<input type="checkbox"/>
Other _____		

<b>Endocrine</b>		
Diabetes Type II	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Dysfunction	<input type="checkbox"/>	<input type="checkbox"/>
Hormonal Dysfunction	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes Type I	<input type="checkbox"/>	<input type="checkbox"/>
Other _____		

<b>Hematologic/Lymphatic</b>		
Large Volume Blood Loss	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Ulcer	<input type="checkbox"/>	<input type="checkbox"/>
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>
Other _____		

<b>Allergic/Immunologic</b>		
Environmental Allergies	<input type="checkbox"/>	<input type="checkbox"/>
Lupus	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Drug Allergies	<input type="checkbox"/>	<input type="checkbox"/>
Sjogrens Syndrome	<input type="checkbox"/>	<input type="checkbox"/>
Other _____		

If you answered yes to any of the above, or have a condition not listed, please explain:  
 \_\_\_\_\_  
 \_\_\_\_\_

Doctor's Signature \_\_\_\_\_ Date \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_