Patients NEW to our office or RETURN patients not seen for 3 years

NAME_____DATE_____

REVIEW OF SYSTEMS—Do you have problems with any of the following:

Allergic/Immunologic			**Endocrine**			**Musculoskeletal**		
Hay Fever/Allergies	Yes	No	Diabetes	Yes	No	Arthritis	Yes	No
Medication Allergies	Yes	No	Thyroid	Yes	No	Rheumatoid	Yes	No
Constitutional Symptoms			Swollen Glands	Yes	No	Muscle Pain	Yes	No
Fever	Yes	No	**Gastrointestinal**			Joint Pain	Yes	No
Weight Loss	Yes	No	Diarrhea	Yes	No	**Neurological**		
Cardiovascular			Constipation	Yes	No	Headaches	Yes	No
Chest Pain	Yes	No	Ulcers	Yes	No	Migraines	Yes	No
High Blood Pressure	Yes	No	**Genitourinary**			Seizures	Yes	No
High Cholesterol	Yes	No	Genitals	Yes	No	**Psychiatric**		
Vascular Disease	Yes	No	Kidney	Yes	No	Nervous Disorders	Yes	No
Ears, Nose, Mouth, Throat			Bladder	Yes	No	Depression	Yes	No
Sinus Problems	Yes	No	**Hematologic/Lymphatic**			Anxiety	Yes	No
Chronic Cough	Yes	No	Anemia	Yes	No	Compulsiveness	Yes	No
Dry Mouth	Yes	No	Bleeding	Yes	No	**Respiratory**		
Chronic Ear Infections	Yes	No	Swelling	Yes	No	Asthma	Yes	No
Sleep Apnea	Yes	No	**Integumentary**			Shortness of Breath	Yes	No
			Skin Rashes	Yes	No	Emphysema	Yes	No
			Breast Problems	Yes	No	Lung Cancer	Yes	No