**Review of Systems** **Patient Name: _________________________**

Please circle **YES** or **NO** to indicate if you ***currently*** have any problems in one or more of the following areas. If yes, please describe or explain the problem in the space provided.

**General/Constitution** Yes / No
(fever, weight loss or gain, tired feeling)

**Skin** Yes / No
(moles, warts, growths, rashes)

**Eyes** Yes / No
(blurred vision, eye pain, discharge, redness, tearing, floaters)

**Ears, Nose, Throat, Mouth** Yes / No
(hearing loss, nasal congestion, ear pain, allergies, hayfever

**Respiratory** Yes / No
(asthma, emphysema, chronic cough, chronic bronchitis, shortness of breath)

**Cardiovascular** Yes / No
(chest pain, angina, poor circulation, irregular heartbeat)

**Gastrointestinal** Yes / No
(abdominal pain, diarrhea, constipation, stomach ulcer)

**Genitourinary** Yes / No
(painful urination, frequent urination, prostate condition, jaundice)

**Lymphatic** Yes / No
(anemia, bleeding problems, problem with blood transfusion)

**Musculoskeletal** Yes / No
(arthritis pain, joint pain, muscle pain, cramps, stiffness, swelling)

**Neurological** Yes / No
(headache, weakness, numbness, dizziness, memory loss)

**Endocrine System** Yes / No
(diabetes, elevated blood sugar, thyroid problems, pituitary problems )

**Psychosocial** Yes / No
(depression, anxiety, sleep disturbance, alcohol/drug use, relationship trouble)

**Patient Signature:___________________________________** **Date: _____________**