Name: _____ Date of Birth: _____

Review of Systems

Eyes*

- Previous Surgery ☐ YES ☐ NO
- Contact Lens ☐ YES ☐ NO
- Pain ☐ YES ☐ NO
- Double Vision ☐ YES ☐ NO
- Glaucoma ☐ YES ☐ NO
- Cataracts ☐ YES ☐ NO
- Macular Degeneration ☐ YES ☐ NO
- Dry Eyes ☐ YES ☐ NO
- Flashes ☐ YES ☐ NO
- Floaters ☐ YES ☐ NO

Ear, Nose, and Throat*

- Hard of Hearing ☐ YES ☐ NO
- Ringing in Ears ☐ YES ☐ NO
- Vertigo ☐ YES ☐ NO

Cardiovascular*

- Chest Pain ☐ YES ☐ NO
- Dizziness ☐ YES ☐ NO
- Fainting Spells ☐ YES ☐ NO
- Shortness of Breath ☐ YES ☐ NO
- Irregular Heart Beat ☐ YES ☐ NO
- Difficulty Lying Flat ☐ YES ☐ NO

Constitutional*

- Fatigue/Weakness ☐ YES ☐ NO
- Fever ☐ YES ☐ NO
- Weight Gain/Loss ☐ YES ☐ NO

Respiratory*

- Cough ☐ YES ☐ NO
- Congestion ☐ YES ☐ NO
- Wheezing ☐ YES ☐ NO
- Asthma ☐ YES ☐ NO

Gastrointestinal*

- Heartburn ☐ YES ☐ NO
- Nausea/Vomiting ☐ YES ☐ NO
- Jaundice/Hepatitis ☐ YES ☐ NO

Genito-Urinary*

- Pain/Difficulty ☐ YES ☐ NO
- Blood in Urine ☐ YES ☐ NO
- History of Kidney Stones ☐ YES ☐ NO
- History of STD's ☐ YES ☐ NO

Psychiatric*

- Anxiety/Depression ☐ YES ☐ NO
- Mood Swings ☐ YES ☐ NO
- Difficulty Sleeping ☐ YES ☐ NO

Endocrine*

- Increased Thirst ☐ YES ☐ NO
- Increased Hunger ☐ YES ☐ NO
- Increased Urination ☐ YES ☐ NO
- Increased Sweating ☐ YES ☐ NO
- Fingernail Changes ☐ YES ☐ NO

Blood/Lymphnodes*

- Easy Bruising ☐ YES ☐ NO
- Gums Bleed Easily ☐ YES ☐ NO
- Prolonged Bleeding ☐ YES ☐ NO
- Heavy Asprin Use ☐ YES ☐ NO

Musculo/Skeletal*

- Stiffness ☐ YES ☐ NO
- Arthritis ☐ YES ☐ NO
- Joint Pain/Swelling ☐ YES ☐ NO

Skin*

- Rash/Sores ☐ YES ☐ NO
- Lesions ☐ YES ☐ NO
- Hives/Eczema ☐ YES ☐ NO

Neurological*

- Seizures ☐ YES ☐ NO
- Weakness/Paralysis ☐ YES ☐ NO
- Numbness ☐ YES ☐ NO
- Tremors ☐ YES ☐ NO

Immunologic*

- Hives ☐ YES ☐ NO
- Itching ☐ YES ☐ NO
- Runny Nose ☐ YES ☐ NO
- Sinus Pressure ☐ YES ☐ NO