

**REVIEW OF SYSTEMS:** *Please check if any of the following apply:*

<i>Today's Date:</i>		
<b>1. CONSTITUTIONAL</b>	Weight loss/gain (unexpl.)	<input type="checkbox"/>
	Headaches	<input type="checkbox"/>
	Fever	<input type="checkbox"/>
	Fatigue	<input type="checkbox"/>
<b>2. EYES</b>	Spots before eyes	<input type="checkbox"/>
	Vision changes	<input type="checkbox"/>
<b>3. ENT/MOUTH</b>	Ear problems	<input type="checkbox"/>
	Ringing in ears	<input type="checkbox"/>
	Sinus problems	<input type="checkbox"/>
<b>4. CARDIOVASCULAR</b>	Chest pain	<input type="checkbox"/>
	Heart racing/skipping beats	<input type="checkbox"/>
<b>5. RESPIRATORY</b>	Wheezing	<input type="checkbox"/>
	Shortness of breath	<input type="checkbox"/>
<b>6. GASTROINTESTINAL</b>	Diarrhea or constipation	<input type="checkbox"/>
	Blood in stool	<input type="checkbox"/>
	Nausea/vomiting	<input type="checkbox"/>
<b>7. GENITOURINARY</b>	Pain with urination	<input type="checkbox"/>
	Frequency/urgency of urination	<input type="checkbox"/>
	Leaking urine	<input type="checkbox"/>
	Heavy periods	<input type="checkbox"/>
	Bleeding between periods	<input type="checkbox"/>
	Pelvic pain	<input type="checkbox"/>
	Pain with intercourse	<input type="checkbox"/>
	Vaginal itching/burning	<input type="checkbox"/>
Abnormal discharge	<input type="checkbox"/>	
<b>8. MUSCULOSKELETAL</b>	Muscle weakness	<input type="checkbox"/>
	Muscle/joint pain	<input type="checkbox"/>
<b>9. SKIN/BREAST</b>	Pain in breast	<input type="checkbox"/>
	Lump in breast	<input type="checkbox"/>
	Nipple discharge	<input type="checkbox"/>
	Rash	<input type="checkbox"/>
	Ulcers/sores	<input type="checkbox"/>
<b>10. NEUROLOGICAL</b>	Dizziness	<input type="checkbox"/>
	Numbness in arms/legs	<input type="checkbox"/>
<b>11. PSYCHIATRIC</b>	Depression or anxiety	<input type="checkbox"/>
<b>12. ENDOCRINE</b>	Heat/cold intolerance	<input type="checkbox"/>
	Abnormal thirst	<input type="checkbox"/>
	Hot flashes	<input type="checkbox"/>
<b>13. HEMATOLOGIC/ LYMPH</b>	Frequent bruises	<input type="checkbox"/>
	Cuts that do not stop bleeding	<input type="checkbox"/>
	Enlarged lymph nodes/glands	<input type="checkbox"/>
<b>14. ALLERG/IMMUNOL.</b>	Allergies (food/pollen/etc.)	<input type="checkbox"/>

Last period:	<input type="checkbox"/> Never	____/____/____
Last pap smear:	<input type="checkbox"/> Never	____/____/____
Last mammogram:	<input type="checkbox"/> Never	____/____/____
Last bone density test:	<input type="checkbox"/> Never	____/____/____
Last colonoscopy:	<input type="checkbox"/> Never	____/____/____

Patient signature \_\_\_\_\_

Date \_\_\_\_\_

Physician signature \_\_\_\_\_

Date \_\_\_\_\_

Reviewed: Date \_\_\_\_\_ Pt initials \_\_\_\_\_ MD/initials \_\_\_\_\_