



Patient Name:

Account #

Date:

Referring Physician:

**REVIEW OF SYSTEMS: Do you currently have any problems in the following areas?**

***Constitutional Symptoms***

- | YES                      | NO                       |                           |
|--------------------------|--------------------------|---------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Fever                     |
| <input type="checkbox"/> | <input type="checkbox"/> | Weight Loss/Poor Appetite |
| <input type="checkbox"/> | <input type="checkbox"/> | Fatigue/Tire Easily       |

- Skin***
- | YES                      | NO                       |                    |
|--------------------------|--------------------------|--------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Easy bruising      |
| <input type="checkbox"/> | <input type="checkbox"/> | Rashes/Facial acne |

***Eyes***

- | YES                      | NO                       |                            |
|--------------------------|--------------------------|----------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Loss of vision             |
| <input type="checkbox"/> | <input type="checkbox"/> | Distorted vision           |
| <input type="checkbox"/> | <input type="checkbox"/> | Double vision              |
| <input type="checkbox"/> | <input type="checkbox"/> | Floating objects in vision |
| <input type="checkbox"/> | <input type="checkbox"/> | Flashing lights            |
| <input type="checkbox"/> | <input type="checkbox"/> | Dryness of eyes            |
| <input type="checkbox"/> | <input type="checkbox"/> | Redness                    |
| <input type="checkbox"/> | <input type="checkbox"/> | Itching                    |
| <input type="checkbox"/> | <input type="checkbox"/> | Burning                    |
| <input type="checkbox"/> | <input type="checkbox"/> | Excess Tearing             |
| <input type="checkbox"/> | <input type="checkbox"/> | Glare/Light Sensitivity    |
| <input type="checkbox"/> | <input type="checkbox"/> | Eye pain or soreness       |
| <input type="checkbox"/> | <input type="checkbox"/> | Crossed Eyes               |
| <input type="checkbox"/> | <input type="checkbox"/> | Lazy eye (amblyopia)       |
| <input type="checkbox"/> | <input type="checkbox"/> | Past eye surgery           |

***Neurological***

- | YES                      | NO                       |                                     |
|--------------------------|--------------------------|-------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Severe headache                     |
| <input type="checkbox"/> | <input type="checkbox"/> | Numbness or tingling of extremities |
| <input type="checkbox"/> | <input type="checkbox"/> | Seizures                            |
| <input type="checkbox"/> | <input type="checkbox"/> | Depression/Psychiatric conditions   |

***Cardiovascular (heart/blood vessels)***

- | YES                      | NO                       |                      |
|--------------------------|--------------------------|----------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Chest pain           |
| <input type="checkbox"/> | <input type="checkbox"/> | Irregular heart beat |

***Respiratory***

- | YES                      | NO                       |                              |
|--------------------------|--------------------------|------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Chronic bronchitis/emphysema |
| <input type="checkbox"/> | <input type="checkbox"/> | Chronic cough                |
| <input type="checkbox"/> | <input type="checkbox"/> | Shortness of breath          |

Type of surgery \_\_\_\_\_

***Ears, Nose, Mouth, Throat***

- | YES                      | NO                       |                             |
|--------------------------|--------------------------|-----------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Recent viral infection      |
| <input type="checkbox"/> | <input type="checkbox"/> | Sore throat                 |
| <input type="checkbox"/> | <input type="checkbox"/> | Loss of hearing or deafness |
| <input type="checkbox"/> | <input type="checkbox"/> | Dryness of mouth            |

***Gastrointestinal***

- | YES                      | NO                       |              |
|--------------------------|--------------------------|--------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Stomach pain |
| <input type="checkbox"/> | <input type="checkbox"/> | Diarrhea     |

***Endocrine***

- | YES                      | NO                       |                  |
|--------------------------|--------------------------|------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Thyroid problems |

***Genitourinary (genitals/kidney/bladder)***

- | YES                      | NO                       |                              |
|--------------------------|--------------------------|------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Burning with urination       |
| <input type="checkbox"/> | <input type="checkbox"/> | Genital sores                |
| <input type="checkbox"/> | <input type="checkbox"/> | Kidney infection or bleeding |

***Allergic - Immunologic***

- | YES                      | NO                       |                     |
|--------------------------|--------------------------|---------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Hay fever symptoms  |
| <input type="checkbox"/> | <input type="checkbox"/> | Skin or respiratory |

***Musculoskeletal***

- | YES                      | NO                       |                          |
|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Muscle or neck pains     |
| <input type="checkbox"/> | <input type="checkbox"/> | Back pain or stiffness   |
| <input type="checkbox"/> | <input type="checkbox"/> | Joint pains or stiffness |

Physician Signature \_\_\_\_\_ Date \_\_\_\_\_