Patient Name: _____ **Account No:** _____

REVIEW OF SYSTEMS

(If Yes, Also Circle the Specific Condition)		NO	YES	MD ONLY
Heart	Chest Pain, Pressure or Discomfort			
	Discomfort in Neck, Throat, Jaw, Shoulders, Upper Back or Arms			
	Unexpected Shortness of Breath			
	Change in *Level of Endurance – "poor endurance"*			
	Palpitation (Skipping or Racing Heart)			
	Passing Out (or nearly passing out)			
	Heart Murmur / Rheumatic Fever / Pericarditis			
	High Blood Pressure (Hypertension)			
	Diabetes			
	High Cholesterol			
	Stroke, TIA (mini-stroke)			
	Have you ever smoked? If Yes, # of Years: ____ Have you Quit? _____ When? _____			
GYN	Have you experienced Menopause? If Yes, Age of Onset _____			
General	Fatigue			
	Appetite Problems? Current Weight _____ Weight Loss _____ Gain _____			
	Poor Sleep (Insomnia)			
	Depression, Mental Health Concerns			
Head	Vision Problems			
	Hearing Problems			
Neck	Thyroid Problems			
	Neck Arthritis, Disc Problem, Whiplash Injury			
Lungs	Airway Obstruction, Asthma, Wheezing			
	Chronic Bronchitis, Emphysema, TB, Blood Clots (pulmonary embolism)			
Digestive	Swallowing Problem			
	Indigestion, Heartburn, Reflux, *Hiatal Hernia*, Belching, Ulcer, Bleeding			
	Liver Problems, Hepatitis, Jaundice, Gall Stones			
	Blood in Bowel Movements – Red or Black			
	Diarrhea, Constipation			
Urology	Kidney Problems			
	Infections, Bleeding, *Kidney* Stones			
	Prostate Problems			
Legs	Swelling			
	Cramping with walking			
	Blood Clots, Varicose Veins			
Joints	Arthritis			
	Low Back Pain			
Skin	Rash, Cancer *(Basal Cell ____ Melanoma _____)*			
Blood	Bleeding or Clotting Problem			
	History of Tranfusions?			