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REVIEW OF SYSTEMS

PATIENT NAME: _____ TODAY'S DATE: _____

TO BE COMPLETED BY PATIENT:

PLEASE CIRCLE ALL THAT APPLY TODAY

1.	GENERAL HEALTH	weight loss/gain	fever/chills	fatigue
2.	SKIN/HAIR	rash	sores	swelling
3.	EYES/VISION	glasses/ contacts	loss of vision	blurred vision
4.	EARS/NOSE/THROAT	ringing in ear (s)	nosebleeds	hoarseness
5.	LUNGS/BREATHING	shortness of breath	wheezing	cough
6.	STOMACH/DIGESTION	nausea/vomiting	diarrhea	heartburn
7.	KIDNEYS/BLADDER	painful urination	blood in urine	frequent urination
8.	BONES/JOINTS	stiffness	back pain	joint pain
9.	BLOOD/CIRCULATION	poor circulation	bruising	bleeding
10.	NERVOUS SYSTEM	headache	seizures	numbness/tingling
11.	CARDIOVASCULAR	chest pain	palpitations	dizziness

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PATIENT SIGNATURE REVIEWED BY PHYSICIAN / SIGNATURE