

Review of Systems

Do you currently, or have you ever had any problems in the following areas: (If YES, please explain and list medications)

System	NO	YES	?	EXPLAIN / MEDICATIONS
INTEGUMENTARY (Skin)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
NEUROLOGIC				_____
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Migraines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
EYES				_____
Loss of Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blurred Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Distorted Vision / Haloes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Loss of Side Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Double Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dryness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Mucous Discharge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Redness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sandy or Gritty Feeling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Itching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Burning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Foreign Body Sensation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Excess Tearing / Watering	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glare / Light Sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eye Pain or Soreness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chronic Infection of Eye or Lid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sties or Chalazion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Flashes / Floaters in Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tired Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
EARS, NOSE, MOUTH, THROAT				_____
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sinus Congestion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Runny Nose	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Post-Nasal Drip	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dry Throat / Mouth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
RESPIRATORY				_____
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chronic Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
VASCULAR				_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Vascular Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
GASTROINTESTINAL				_____
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
GENITOURINARY (genitals / kidney / bladder)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
BONES / JOINTS / MUSCLES				_____
Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Muscle Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
LYMPHATIC / HEMATOLOGIC				_____
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bleeding Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
ENDOCRINE (thyroid / other glands)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
PSYCHIATRIC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Doctor's Signature

Review Date