Review of Systems

Name: ________________________________ Date: ____________________

Please mark if you have experienced any of these symptoms within the last month:

Y	N	***Neurological***
___	___	Migraines
___	___	Headaches
___	___	Slurring of Speech
___	___	Ringing in Ears
___	___	Numbness
		Ears/Nose/Throat
___	___	Altered Taste/Smell
___	___	Night Blindness
___	___	Sore Throat
___	___	Gingivitis
___	___	Nose Bleeds
		Cardiovascular
___	___	Chest Pain
___	___	Palpitations- Racing Heart Beat
___	___	Swelling in Hands & Feet
___	___	Anemia
		Respiratory
___	___	Recurrent Respiratory Infection
___	___	Asthma
___	___	Chest Congestion
___	___	Wheezing
___	___	Frequent Sneezing
		GI
___	___	Stomach Pains or Cramping
___	___	Constipation
___	___	Reflux or Heartburn
___	___	Bloating
___	___	Gas
___	___	Nausea or Vomiting
		Musculoskeletal
___	___	Joint Pain
___	___	Arthritis
___	___	Chronic Pain
___	___	Muscle Aches

Y	N	***Skin***
___	___	Eczema
___	___	Dermatitis
___	___	Excessive Sweating
___	___	Rashes
___	___	Brittle Nails
___	___	Increased Bleeding
___	___	Hair Loss
___	___	Easy Bruising
		Genitourinary
___	___	Uterine Fibrosis
___	___	Ovarian Cysts
___	___	Cancer (Breast, Ovarian, Prostate, Uterine)
___	___	Prostate Problems
		Emotional/Mental
___	___	Depression
___	___	Anxiety
___	___	Mood Swings
___	___	Irritability
___	___	Memory Loss
___	___	Confusion
		Energy
___	___	Fatigue
___	___	Hyperactivity
___	___	Restlessness
___	___	Insomnia
___	___	Decreased Libido
___	___	Stress
		Weight
___	___	Decreased Appetite
___	___	Weight Gain
___	___	Inability to Lose Weight
___	___	Food Cravings
___	___	Binge Eating
___	___	Water Retention