Review of Systems

Name ______________________________ Date _______________

Please check any medical health issues that you have now or have had in the past.

Constitution:	Ear, Nose, and Throat:	Cardio:	Hematological/Lymph:
☐ Cancer ☐ Fatigue Syndrome ☐ Development Disabilities	☐ Sinusitis ☐ Dry Mouth ☐ Hearing Loss ☐ Laryngitis	☐ CHF ☐ CVA Heart Disease ☐ Vascular Disease ☐ Hypertension	☐ Ulcer ☐ Blood loss ☐ High cholesterol ☐ Anemia
Neurological:	**Respiratory:**	**Gastrointestinal:**	**GU (Genitourinary):**
☐ Epilepsy ☐ Migraines ☐ Stroke ☐ Cerebral Palsy ☐ Tumors ☐ MS	☐ Sleep Apnea ☐ Bronchitis ☐ COPD ☐ Asthma ☐ Emphysema ☐ Cigarette Smoker	☐ Acid Reflux ☐ Chron's ☐ Celiac Disease ☐ Ulcer ☐ Colitis	☐ STD's-herpes ☐ Chlamydia ☐ Stroke ☐ Cerebral Palsy ☐ Tumors ☐ Cerebral Palsy
Musculoskeletal:	**Integumentary:**	**Endocrine:**	**Psychological**
☐ Arthritis ☐ Fibromyalgia ☐ Gout ☐ Osteoporosis ☐ Muscular Dystrophy ☐ Osteoarthritis ☐ Ankylosing Spondylitis	☐ Shingles ☐ Eczema ☐ Psoriasis ☐ Cold Sores	☐ Thyroid ☐ Type 1 Diabetes (child onset) ☐ Type 2 Diabetes (adult onset) ☐ Hormonal dysfunction	☐ Bipolar ☐ Anxiety ☐ Depression ☐ Attention Deficit Disorder (ADD)
Allergy/Immune	**Please list any surgeries you have had in the past:**		
☐ Drug Allergies ☐ Lupus ☐ Environmental Allergies ☐ Sjogren's Syndrome ☐ Rheumatoid Arthritis			
Please list any eye or medical problems in the family:			