Review of systems:
Please tell us if you suffer any of the previous problems (fill in all circles in all questions)

Constitutional

	No	Yes		No	Yes		No	Yes
Weight gain	0	0	Amount __________lbs			Since __________________		
Weight loss	0	0	Amount __________lbs			Since __________________		
Fever	0	0	Weakness	0	0	Loss of appetite	0	0
Fatigue	0	0						

Neurology

Loss of consciousness	0	0	Headache	0	0	Tingling/numbness	0	0
Seizures	0	0	Tremors	0	0	Burning pain feet/hands	0	0
Muscle weakness	0	0	Dizziness	0	0	Memory loss	0	0
Difficulty walking	0	0						

Psychology

Excessive anger	0	0	Depression	0	0	Difficulty falling sleep	0	0
Difficulty staying sleep	0	0	Mood swings	0	0	Anxiety	0	0

Ophthalmology

Feels something in eyes	0	0	Blurred vision	0	0	Double vision	0	0
Dry eyes	0	0	Redness in eyes	0	0	Itchy eyes	0	0
Change in vision	0	0	Pain in eyes	0	0			

Ear Nose and Throat

Sores in mouth	0	0	Loss of hearing	0	0	Runny nose	0	0
Dryness in mouth	0	0	Ringing in ears	0	0	Sore throat	0	0
Hoarseness	0	0	Pain in mouth	0	0	Nosebleeds	0	0

Respiratory

Pain with deep breath	0	0	Wheezing	0	0	Cough up blood	0	0
Cough	0	0	Difficulty breathing at night	0	0	Chest congestion	0	0

Cardiovascular

Chest pains	0	0	Palpitations	0	0	Shortness of breath	0	0
Leg swelling	0	0	Heart murmurs	0	0			

Gastroenterology

Nausea	0	0	Vomiting	0	0	Pain on swallowing	0	0
Abdominal pain	0	0	Heartburn	0	0	Constipation	0	0
Diarrhea	0	0	Blood in stool	0	0	Change in bowel habits	0	0

Urology

Difficulty urinating	0	0	Pain to urinate	0	0	Frequent urination	0	0
Change in color of urine	0	0	Waking up at night to urinate	0	0			

Dermatology

Hair loss	0	0	Change in color hand/feet with cold	0	0	Easy Bruising	0	0
Rash	0	0	Dry or sensitive skin	0	0	Hives	0	0
Allergy to the sun	0	0						

Endocrinology

Excessive thirst	0	0	Cold intolerance	0	0

Hematology/Lymph

Swollen glands	0	0	Easy bruising	0	0	Easy bleeding	0	0
Anemia	0	0	Transfusions	0	0			

Infectious/Allergy

Frequent sneezing	0	0	Frequent infections	0	0