Patient Name: _____ Appointment Date: _____/_____/_____

Account #: _____

Review of Systems: Please check [√] any of the following symptoms you are having:

Constitutional	**Integumentary**	**Neurological**
☐ unexplained weight loss: _____lbs.	☐ rashes	☐ headache
☐ unexplained weight gain: _____lbs.	☐ frequent bruising	☐ blackouts and fainting
☐ night sweats	☐ hives	☐ tingling / numbness
☐ fevers/chills	☐ sores that don't heal	☐ paralysis
☐ loss of appetite	☐ NONE	☐ seizures
☐ NONE		☐ memory loss
		☐ NONE
Eyes	**Cardiovascular**	**Ear/Nose/Throat**
☐ blurry vision	☐ chest pain/pressure/tightness	☐ vertigo/dizziness
☐ double vision	☐ palpitations	☐ ringing in the ear
☐ eye pain	☐ trouble breathing while lying	☐ nose bleed
☐ NONE	☐ NONE	☐ sinusitis
		☐ trouble swallowing
		☐ hearing aid
		☐ NONE
Respiratory	**Psychological**	**Gastrointestinal**
☐ shortness of breath	☐ depression	☐ stomach pain/heart burn
☐ COPD	☐ anxiety	☐ bloody or dark stools
☐ chronic cough	☐ NONE	☐ constipation
☐ NONE		☐ diarrhea
		☐ nausea/vomiting
		☐ NONE
Musculoskeletal	**Genitourinary**	
☐ joint pain	☐ blood in the urine	
☐ joint redness and swelling	☐ painful urination	
☐ leg pain with walking	☐ urgency to urinate	
☐ muscle cramps	☐ loss of bladder control	
☐ weakness	☐ frequent urination	
☐ NONE	☐ difficulty urinating	
	☐ NONE	

I acknowledge, I have reviewed the above information and have completed the form to the best of my ability.

_____ _____

Patient Signature M.D. Signature

For Clinical Use only

Ht. _____ **Wt.** _____ **B/P** _____ **P** _____ **BMI:**_____