Review of Systems

Please indicate if you are **CURRENTLY** experiencing any of the following symptoms (check all that apply):

Constitutional: ☐ Decreased Appetite ☐ Chills ☐ Fever ☐ Other_________ ☐ NONE_________

Eyes: ☐ Blurry Vision ☐ Eye Discharge ☐ Other_________ ☐ NONE _________

ENT/Mouth: ☐ Stuffy/Congested Nose ☐ Tongue Swelling ☐ Ear Pain ☐ Other_________ ☐ NONE_________

Allergy/Immune: ☐ Allergies ☐ Asthma ☐ Other_________ ☐ NONE_________

Cardiovascular: ☐ Chest Pain ☐ Palpitations ☐ Other________ ☐ NONE_________

Respiratory: ☐ Cough ☐ Shortness of Breath ☐ Wheezing ☐ Other_________ ☐ NONE_________

Endocrine: ☐ Excess Thirst ☐ Frequent Urination ☐ Cold Intolerance ☐ Heat Intolerance ☐ Other_________ ☐ NONE_________

GI: ☐ Abdominal Pain ☐ Constipation ☐ Diarrhea ☐ Heartburn/Acid Reflux ☐ Nausea ☐ Vomiting ☐ Other_________ ☐ NONE_________

Skin/Breast: ☐ Rash ☐ Other_________ ☐ NONE _________

Musculoskeletal: ☐ Joint Pain ☐ Spasm ☐ Swelling ☐ Muscle Aches ☐ Other_________ ☐ NONE_________

Neuro: ☐ Dizziness ☐ Seizure ☐ Weakness ☐ Tremors ☐ Other_________ ☐ NONE_________

Psych: ☐ Anxiety ☐ Suicidal Thoughts ☐ Depression ☐ Other_________ ☐ NONE _________

Genitourinary: ☐ Difficulty Voiding ☐ Bladder Pain ☐ Pain with Urination ☐ Frequency ☐ Urgency ☐ Prostate Problems ☐ Flank Pain ☐ Blood in Urine ☐ Other_________ ☐ NONE_________