

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

**REVIEW OF SYSTEMS:**

Which of the following symptoms do you presently have?

- |  |  |
|--|--|
| <input type="checkbox"/> FEVER                 | <input type="checkbox"/> WATERY EYES                 |
| <input type="checkbox"/> WEIGHT GAIN           | <input type="checkbox"/> ITCHY EYES                  |
| <input type="checkbox"/> WEIGHT LOSS           | <input type="checkbox"/> HEARTBURN                   |
| <input type="checkbox"/> FATIGUE               | <input type="checkbox"/> ACID REFLUX                 |
| <input type="checkbox"/> LUMPS IN NECK         | <input type="checkbox"/> STOMACH PAIN                |
| <input type="checkbox"/> HEARING LOSS          | <input type="checkbox"/> PALPITATIONS                |
| <input type="checkbox"/> DIZZINESS             | <input type="checkbox"/> SHORTNESS OF BREATH         |
| <input type="checkbox"/> EAR PAIN              | <input type="checkbox"/> WHEEZING                    |
| <input type="checkbox"/> DIFFICULTY SWALLOWING | <input type="checkbox"/> COUGH                       |
| <input type="checkbox"/> HOARSENESS            | <input type="checkbox"/> BLOOD TRANSFUSION           |
| <input type="checkbox"/> NASAL CONGESTION      | <input type="checkbox"/> BRUISING                    |
| <input type="checkbox"/> RUNNY NOSE            | <input type="checkbox"/> SENSITIVITY TO HEAT OR COLD |
| <input type="checkbox"/> SORE THROAT           | <input type="checkbox"/> SKIN LESION                 |
| <input type="checkbox"/> SNEEZING              | <input type="checkbox"/> SKIN RASH                   |
| <input type="checkbox"/> FACIAL PRESSURE       | <input type="checkbox"/> WEAKNESS ARMS OR LEGS       |
| <input type="checkbox"/> HEADACHE              | <input type="checkbox"/> NUMBNESS ARMS OR LEGS       |

DATE OF LAST MENSTRUAL PERIOD (IF APPLICABLE) \_\_\_\_\_

ALLERGIES: \_\_\_\_\_

\_\_\_\_\_

CURRENT MEDICATIONS: \_\_\_\_\_

\_\_\_\_\_