

REVIEW OF SYSTEM

Please ✓ any that you have or have had in the past 6 months.

- Headache _____
- Fainting or dizziness (circle if yes) _____
- Blurred vision or double vision (circle if yes) _____
- Spots before eyes _____
- Conjunctivitis _____
- Change in Vision _____
Do you wear eyeglasses/contact lenses? No Yes _____
Date of last eye exam? _____
- Earaches or discharge from ears (circle if yes) _____
- Ringing in ears or decreased hearing (circle if yes) _____
- Nosebleeds _____
- Frequent headcolds _____
- Sinusitis _____
- Hay Fever _____
- Strange, persistent odors or tastes (circle if yes) _____
- Loss of taste _____
- Persistent Laryngitis _____
- Enlarged glands _____
- Recurrent sore throats _____
- Recurrent sores in mouth _____
- Soreness or bleeding of gums on brushing _____
- Chest pain _____
- Angina _____
- Coughing up blood _____
- Pain in arm(s) _____
- Night sweats _____
- Chronic or frequent cough: Productive or Dry (circle one) _____
- Shortness of breath: _____
 - Wakes you up _____
 - On walking several blocks _____
 - On walking one flight of stairs _____
 - On lying down _____
- Purple lips or fingers _____
- Palpitations or fluttering of heart _____
- Swelling of hands, feet or ankles AM PM (circle if yes) _____
- Leg cramps: on walking at night (circle if yes) _____
- Enlarged veins in legs _____
- Belching, heartburn, indigestion _____
- Trouble swallowing _____
Appetite Good Fair Poor _____
- Nausea or vomiting _____
- Avoidance of any foods _____

Additional Information:

- Abdominal pain or cramps _____
- Diarrhea _____
- Constipation _____
- Blood in stool _____
- Rectal pain _____
- Difficulty in urination _____
- Do you get up at night to urinate _____
How many times _____
- Any blood in urine _____
- Lose urine on coughing or sneezing _____
- Backaches _____
- Joint pain or swelling _____
- Tingling or weakness of hands or feet _____
- Loss or change in sensation of hands or feet _____
- Trembling of any extremity _____
- Growth in neck or throat _____
- Hot flashes _____
- Dryness of skin _____
- Easy bruising _____
- Inability to stand heat/cold (circle if yes) _____
- Change in hair texture or skin texture _____
- Any skin rash _____

List any other conditions for which you are treated and/or with which you are diagnosed:

NOTE: This is a confidential record of your medical history and will be kept in this office. Information contained here will not be released to any person except when you have authorized us to do so.

Patient Signature _____ Date _____

Reviewed by _____ Date _____