REVIEW OF SYSTEMS

- Do you currenty, or have you in the past, had any of the following problems?
  (Please write details if necessary. Please list any medications you are taking for each problem.)

SYSTEM	NO	YES	UNSURE/ BORDERLINE	MORE INFO/MEDICATIONS
GENERAL (weight gain / fatigue / etc.)	☐	☐	☐	
EARS, NOSE, MOUTH, THROAT				
Sinus Congestion (chronic or recurrent)	☐	☐	☐	
Cough (chronic or recurrent)	☐	☐	☐	
Dry Throat / Mouth (chronic or recurrent)	☐	☐	☐	
Other	☐	☐	☐	
VASCULAR				
High Blood Pressure	☐	☐	☐	
Vascular Disease	☐	☐	☐	
RESPIRATORY				
Asthma	☐	☐	☐	
Chronic Bronchitis	☐	☐	☐	
Emphysema	☐	☐	☐	
GASTROINTESTINAL				
Diarrhea (chronic or recurrent)	☐	☐	☐	
Constipation (chronic or recurrent)	☐	☐	☐	
GENITOURINARY (genitals / kidney / bladder)	☐	☐	☐	
BONES / JOINTS / MUSCLES				
Arthritis	☐	☐	☐	
Muscle Pain	☐	☐	☐	
Joint Pain	☐	☐	☐	
SKIN (Eczema / Rosacea / Hair / Nails)	☐	☐	☐	
NEUROLOGIC				
Headaches	☐	☐	☐	
Migraines	☐	☐	☐	
Seizures	☐	☐	☐	
PSYCHIATRIC				
Anxiety	☐	☐	☐	
Depression	☐	☐	☐	
ADD/ADHD	☐	☐	☐	
ENDOCRINE				
Diabetes	☐	☐	☐	
Thyroid	☐	☐	☐	
Other glands	☐	☐	☐	
LYMPHATIC / HEMATOLOGIC				
Anemia	☐	☐	☐	
Bleeding Problems	☐	☐	☐	
ALLERGIC / IMMUNOLOGIC				
Allergies	☐	☐	☐	
Lupus	☐	☐	☐	
Autoimmune disease	☐	☐	☐	
OTHER: ______				
OTHER: ______				
OTHER: ______				
OTHER: ______				
EYES				
Loss of Vision (central or peripheral)	☐	☐	☐	
Blurred Vision	☐	☐	☐	
Distorted Vision	☐	☐	☐	
Halos / Glare	☐	☐	☐	
Light Sensitivity	☐	☐	☐	
Double Vision	☐	☐	☐	
Dryness	☐	☐	☐	
Sticky Discharge	☐	☐	☐	
Tearing	☐	☐	☐	
Redness	☐	☐	☐	
Gritty Feeling	☐	☐	☐	
Itching	☐	☐	☐	
Burning	☐	☐	☐	
Foreign Body Sensation	☐	☐	☐	
Eye Pain or Soreness	☐	☐	☐	
Chronic Infection of Eye / Lid	☐	☐	☐	
Floaters (chronic or new)	☐	☐	☐	
Flashes of light in Vision	☐	☐	☐	
Tired Eyes	☐	☐	☐	
Eye Trauma (foreign body, scratch, blunt trauma, etc.)	☐	☐	☐	
Pathology (Glaucoma, Macular Degeneration, Etc.)	☐	☐	☐	
Eye Surgery (Cataract, LASIK, Eye Muscle, Etc.)	☐	☐	☐	

Doctor's Signature ______________________ Review Date: ______________