

Review of Systems

Please check each item "yes" or "no" as the relate to your health

	Yes	No		Yes	No		Yes	No
	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
EYES			Respiratory			Blood/Lymph		
Surgery	<input type="checkbox"/>	<input type="checkbox"/>	Congestion	<input type="checkbox"/>	<input type="checkbox"/>	Easy bruising	<input type="checkbox"/>	<input type="checkbox"/>
Contacts	<input type="checkbox"/>	<input type="checkbox"/>	Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	Gums Bleed easily	<input type="checkbox"/>	<input type="checkbox"/>
Pain	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Prolonged bleeding	<input type="checkbox"/>	<input type="checkbox"/>
Double Vision	<input type="checkbox"/>	<input type="checkbox"/>				Heavy Aspirin use	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Gastro			Musculo/Skeletal		
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	Heartburn	<input type="checkbox"/>	<input type="checkbox"/>	Joint pain	<input type="checkbox"/>	<input type="checkbox"/>
Mac Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	Nausea/vomit	<input type="checkbox"/>	<input type="checkbox"/>	Joint swelling	<input type="checkbox"/>	<input type="checkbox"/>
			Jaundice/Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Stiffness	<input type="checkbox"/>	<input type="checkbox"/>
ENT			Genito-unary			Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Hearing loss	<input type="checkbox"/>	<input type="checkbox"/>	Pain/difficulty	<input type="checkbox"/>	<input type="checkbox"/>			
Ringin in Ears	<input type="checkbox"/>	<input type="checkbox"/>	Blood/urine	<input type="checkbox"/>	<input type="checkbox"/>	Skin		
Vertigo	<input type="checkbox"/>	<input type="checkbox"/>	Kidney stones	<input type="checkbox"/>	<input type="checkbox"/>	Rash/sores	<input type="checkbox"/>	<input type="checkbox"/>
Cardiovascular	<input type="checkbox"/>	<input type="checkbox"/>	STD	<input type="checkbox"/>	<input type="checkbox"/>	Lesions	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>				Hives/eczema	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric			Neurological		
Fainting	<input type="checkbox"/>	<input type="checkbox"/>	Anxiety/depression	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Short of breath	<input type="checkbox"/>	<input type="checkbox"/>	Mood swings	<input type="checkbox"/>	<input type="checkbox"/>	Weakness/paralysis	<input type="checkbox"/>	<input type="checkbox"/>
Irregular heart beat	<input type="checkbox"/>	<input type="checkbox"/>	Difficult sleep	<input type="checkbox"/>	<input type="checkbox"/>	Numbness	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty in laying flat	<input type="checkbox"/>	<input type="checkbox"/>				Tremors	<input type="checkbox"/>	<input type="checkbox"/>
						Memory loss	<input type="checkbox"/>	<input type="checkbox"/>

Additional Comments: _____
