Review of Systems – (Check box if you have had trouble with any of the following)

Cardiovascular				**Respiratory**				**Allergic/Immunologic**			
	Past	**Present**	**No**		**Past**	**Present**	**No**		**Past**	**Present**	**No**
Poor Circulation				Asthma				Hives			
Hypertension				Tuberculosis				Immune Disorder			
Aortic Aneurism				Short Breath				HIV/AIDS			
Heart Disease				Emphysema				Allergy Shots			
Heart Attack				Cold/Flu				Cortisone Use			
Chest Pain				Cough							
High Cholesterol				Wheezing							
Pace Maker								**Ear, Nose and Throat**			
Jaw Pain				**Eyes**					**Past**	**Present**	**No**
Irregular Heartbeat					**Past**	**Present**	**No**	Difficulty Swallowing			
Swelling of legs				Glaucoma				Dizziness			
				Double Vision				Hearing Loss			
Genitourinary				Blurred Vision				Sore Throat			
	Past	**Present**	**No**					Nosebleeds			
Kidney Disease				**Psychiatric**				Bleeding Gums			
Burning Urination					**Past**	**Present**	**No**	Sinus Infections			
Frequent Urination				Depression							
Blood in Urine				Anxiety				**Gastrointestinal**			
Kidney Stones				Stress					**Past**	**Present**	**No**
Lower Side Pain								Gall Bladder Problems			
				Endocrine				Bowel Problems			
Neurologic					**Past**	**Present**	**No**	Constipation			
	Past	**Present**	**No**	Thyroid				Liver Problems			
Stroke				Diabetes				Ulcers			
Seizures				Hair Loss				Diarrhea			
Head Injury				Menopausal				Nausea/Vomiting			
Brain Aneurysm				PMS				Bloody Stools			
Numbness								Poor Appetite			
Severe Headaches				**Hematologic**							
Pinched Nerves					**Past**	**Present**	**No**	**Musculoskeletal**			
Parkinson's				Hepatitis					**Past**	**Present**	**No**
Carpal Tunnel				Blood Clots				Gout			
Vertigo				Cancer				Arthritis			
				Bruising				Joint Stiffness			
Constitutional				Bleeding				Muscle Weakness			
	Past	**Present**	**No**	Fever, Chills				Osteoporosis			
				Sweating				Broken Bones			
Weight Loss/Gain				Varicose Vein				Joints Replaced			
Low Energy Level								Neck Pain			
Difficulty Sleeping								Low Back Pain			
								Upper Back Pain			

Please list all current medications being taken _____

_____

How are your symptoms changing? Getting better Not changing Getting worse

Are You Pregnant? (Circle) **Yes No**

Patient Name_____ **Date**_____