

## Review Of Symptoms

**NAME:** \_\_\_\_\_

**DOB:** \_\_\_\_\_

<u><b>EYES</b></u>	<b>YES</b>	<b>NO</b>	<u><b>Respiratory</b></u>	<b>YES</b>	<b>NO</b>	<u><b>Blood/Lymphnodes</b></u>	<b>YES</b>	<b>NO</b>
Previous Surgery	<input type="checkbox"/>	<input type="checkbox"/>	Cough	<input type="checkbox"/>	<input type="checkbox"/>	Easy Bruising	<input type="checkbox"/>	<input type="checkbox"/>
Contact Lens	<input type="checkbox"/>	<input type="checkbox"/>	Congestion	<input type="checkbox"/>	<input type="checkbox"/>	Gums Bleed Easily	<input type="checkbox"/>	<input type="checkbox"/>
Pain	<input type="checkbox"/>	<input type="checkbox"/>	Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	Prolonged Bleeding	<input type="checkbox"/>	<input type="checkbox"/>
Double Vision	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Heavy Aspirin Use	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>						
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	<u><b>Gastrointestinal</b></u>	<b>YES</b>	<b>NO</b>	<u><b>MusculoSkeletal</b></u>	<b>YES</b>	<b>NO</b>
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	Heartburn	<input type="checkbox"/>	<input type="checkbox"/>	Stiffness	<input type="checkbox"/>	<input type="checkbox"/>
Dry Eyes	<input type="checkbox"/>	<input type="checkbox"/>	Nausea/Vomiting	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Flashes	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice/Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Joint Pain/Swelling	<input type="checkbox"/>	<input type="checkbox"/>
Floaters	<input type="checkbox"/>	<input type="checkbox"/>						
			<u><b>Genito-Urinary</b></u>	<b>YES</b>	<b>NO</b>	<u><b>Skin</b></u>	<b>YES</b>	<b>NO</b>
<u><b>Ear, Nose, and Throat</b></u>	<b>YES</b>	<b>NO</b>	Pain/Difficulty	<input type="checkbox"/>	<input type="checkbox"/>	Rash/Sores	<input type="checkbox"/>	<input type="checkbox"/>
Hard of Hearing	<input type="checkbox"/>	<input type="checkbox"/>	Blood in Urine	<input type="checkbox"/>	<input type="checkbox"/>	Lesions	<input type="checkbox"/>	<input type="checkbox"/>
Ringing in Ears	<input type="checkbox"/>	<input type="checkbox"/>	History of Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/>	Hives/Eczema	<input type="checkbox"/>	<input type="checkbox"/>
Vertigo	<input type="checkbox"/>	<input type="checkbox"/>	History of STD'S	<input type="checkbox"/>	<input type="checkbox"/>			
						<u><b>Neurological</b></u>	<b>YES</b>	<b>NO</b>
<u><b>Cardiovascular</b></u>	<b>YES</b>	<b>NO</b>	<u><b>Psychiatric</b></u>	<b>YES</b>	<b>NO</b>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	Anxiety/Depression	<input type="checkbox"/>	<input type="checkbox"/>	Weakness/Paralysis	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Mood Swings	<input type="checkbox"/>	<input type="checkbox"/>	Numbness	<input type="checkbox"/>	<input type="checkbox"/>
Fainting Spells	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty Sleeping	<input type="checkbox"/>	<input type="checkbox"/>	Tremors	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>						
Irregular Heart Beat	<input type="checkbox"/>	<input type="checkbox"/>	<u><b>Endocrine</b></u>	<b>YES</b>	<b>NO</b>	<u><b>Immunologic</b></u>	<b>YES</b>	<b>NO</b>
Difficulty Lying Flat	<input type="checkbox"/>	<input type="checkbox"/>	Increased Thirst	<input type="checkbox"/>	<input type="checkbox"/>	Hives	<input type="checkbox"/>	<input type="checkbox"/>
			Increased Hunger	<input type="checkbox"/>	<input type="checkbox"/>	Itching	<input type="checkbox"/>	<input type="checkbox"/>
<u><b>Constitutional</b></u>	<b>YES</b>	<b>NO</b>	Increased Urination	<input type="checkbox"/>	<input type="checkbox"/>	Runny Nose	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue/Weakness	<input type="checkbox"/>	<input type="checkbox"/>	Increased Sweating	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Fever	<input type="checkbox"/>	<input type="checkbox"/>	Fingernail Changes	<input type="checkbox"/>	<input type="checkbox"/>			
Weight Gain/ Loss	<input type="checkbox"/>	<input type="checkbox"/>						