

REVIEW OF SYSTEMS (Information to be completed by Nurse)

	Check here if you have had this condition in the past	Check here if you currently have this condition		Check here if you have had this condition in the past	Check here if you currently have this condition		Check here if you have had this condition in the past	Check here if you currently have this condition
CARDIOVASCULAR			INTEGUMENTARY			MUSCULOSKELETAL (CONT.)		
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Eczema	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Congenital heart disease	<input type="checkbox"/>	<input type="checkbox"/>	Itching	<input type="checkbox"/>	<input type="checkbox"/>	Degenerative joint disease	<input type="checkbox"/>	<input type="checkbox"/>
Chest pain	<input type="checkbox"/>	<input type="checkbox"/>	Rashes	<input type="checkbox"/>	<input type="checkbox"/>	Muscle Weakness	<input type="checkbox"/>	<input type="checkbox"/>
Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>	Hair Loss	<input type="checkbox"/>	<input type="checkbox"/>	which _____		
Mitral valve prolapse	<input type="checkbox"/>	<input type="checkbox"/>	Abnormal Scarring	<input type="checkbox"/>	<input type="checkbox"/>	Muscle pain	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath during activity	<input type="checkbox"/>	<input type="checkbox"/>	Changes in the nails	<input type="checkbox"/>	<input type="checkbox"/>	which _____		
Swelling of feet, ankles or hands	<input type="checkbox"/>	<input type="checkbox"/>	Abnormal skin growth	<input type="checkbox"/>	<input type="checkbox"/>	Tremors	<input type="checkbox"/>	<input type="checkbox"/>
Heart attack	<input type="checkbox"/>	<input type="checkbox"/>	Changes in color	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty in walking	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Any abnormal growth or mass in the breasts	<input type="checkbox"/>	<input type="checkbox"/>	NEUROLOGICAL		
Intermittent Claudication	<input type="checkbox"/>	<input type="checkbox"/>	HEAD AND NECK			Seizures or convulsions	<input type="checkbox"/>	<input type="checkbox"/>
Deep venous thrombosis	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Paralysis	<input type="checkbox"/>	<input type="checkbox"/>
Phlebitis	<input type="checkbox"/>	<input type="checkbox"/>	Migraine	<input type="checkbox"/>	<input type="checkbox"/>	Numbness or tingling sensations	<input type="checkbox"/>	<input type="checkbox"/>
Congestive Heart Failure	<input type="checkbox"/>	<input type="checkbox"/>	Head Injuries	<input type="checkbox"/>	<input type="checkbox"/>	Incoordination	<input type="checkbox"/>	<input type="checkbox"/>
RESPIRATORY			Vertigo	<input type="checkbox"/>	<input type="checkbox"/>	Poliomyelitis	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	HEMATOLOGICAL / LYMPHATIC		
Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	Fainting Spells	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	GASTROINTESTINAL			Prolonged Bleeding	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Nausea and vomiting	<input type="checkbox"/>	<input type="checkbox"/>	Bruises easily	<input type="checkbox"/>	<input type="checkbox"/>
Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	Past transfusions	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Obstructive Pulmonary Disease	<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes Mellitus	<input type="checkbox"/>	<input type="checkbox"/>
Frequent coughs	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	how many years _____	<input type="checkbox"/>	<input type="checkbox"/>
EAR, NOSE, MOUTH, THROAT AND EYES			Hepatitis, Type	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>
Hearing deficit	<input type="checkbox"/>	<input type="checkbox"/>	Cirrhosis of the liver	<input type="checkbox"/>	<input type="checkbox"/>	Other glandular or hormonal problems	<input type="checkbox"/>	<input type="checkbox"/>
Ringling in the ear	<input type="checkbox"/>	<input type="checkbox"/>	Gall stones	<input type="checkbox"/>	<input type="checkbox"/>	Intolerance to heat or cold	<input type="checkbox"/>	<input type="checkbox"/>
Ear infection	<input type="checkbox"/>	<input type="checkbox"/>	Hernias	<input type="checkbox"/>	<input type="checkbox"/>	Excessive sweating	<input type="checkbox"/>	<input type="checkbox"/>
Visual deficit	<input type="checkbox"/>	<input type="checkbox"/>	Hiatal hernia	<input type="checkbox"/>	<input type="checkbox"/>	Excessive thirst	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Blood in the stool	<input type="checkbox"/>	<input type="checkbox"/>	Anorexia	<input type="checkbox"/>	<input type="checkbox"/>
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	Crohn's disease	<input type="checkbox"/>	<input type="checkbox"/>	Recent weight gain or loss	<input type="checkbox"/>	<input type="checkbox"/>
Infection	<input type="checkbox"/>	<input type="checkbox"/>	Colitis	<input type="checkbox"/>	<input type="checkbox"/>	PSYCHIATRIC		
Nose Bleeds	<input type="checkbox"/>	<input type="checkbox"/>	GENTOURINARY			Nervousness	<input type="checkbox"/>	<input type="checkbox"/>
Polyps	<input type="checkbox"/>	<input type="checkbox"/>	Incontinence	<input type="checkbox"/>	<input type="checkbox"/>	Anxiety	<input type="checkbox"/>	<input type="checkbox"/>
Sinusitis	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>
Recurrent Colds	<input type="checkbox"/>	<input type="checkbox"/>	Excessive urination	<input type="checkbox"/>	<input type="checkbox"/>	Insomnia	<input type="checkbox"/>	<input type="checkbox"/>
Loss of sense of smell	<input type="checkbox"/>	<input type="checkbox"/>	Blood in the urine	<input type="checkbox"/>	<input type="checkbox"/>	Memory loss or confusion	<input type="checkbox"/>	<input type="checkbox"/>
Sores in the mouth or tongue	<input type="checkbox"/>	<input type="checkbox"/>	Venereal disease	<input type="checkbox"/>	<input type="checkbox"/>	Do you have any psychiatric illness?	<input type="checkbox"/>	<input type="checkbox"/>
Dentures	<input type="checkbox"/>	<input type="checkbox"/>	MUSCULOSKELETAL			OB / GYN		
Sore throat (tonsillitis)	<input type="checkbox"/>	<input type="checkbox"/>	Gout	<input type="checkbox"/>	<input type="checkbox"/>	Gravida _____ Para _____		
Teeth or gum problems	<input type="checkbox"/>	<input type="checkbox"/>	Pain in the joints	<input type="checkbox"/>	<input type="checkbox"/>	Miscarriage _____		
Difficulty swallowing	<input type="checkbox"/>	<input type="checkbox"/>	which _____			Date of last PAP smear _____		
			Joint stiffness	<input type="checkbox"/>	<input type="checkbox"/>	Date of last mensus _____		
			which _____			Are you pregnant? _____		
						How many months _____		
						IMMUNOLOGIC		
						AIDS or HIV+ _____		
						Recurrent infections _____ where _____		

CURRENT MEDICATIONS

(Medicines will be completed by nurse. Do not fill in this portion.)

ALLERGIES TO MEDICATIONS AND FOODS: