

Review of SYSTEMS

Please check all that apply:

Negative

Ophthalmologic	<input type="checkbox"/>	<input type="checkbox"/> Glaucoma <input type="checkbox"/> Cataracts <input type="checkbox"/> Blindness Other/Comments:_____
Otolaryngologic	<input type="checkbox"/>	<input type="checkbox"/> Hearing Loss <input type="checkbox"/> Dysphasia/Swallowing <input type="checkbox"/> Dizziness <input type="checkbox"/> Chronic sinusitis <input type="checkbox"/> Neck Mass Other/Comments:_____
Cardiovascular	<input type="checkbox"/>	<input type="checkbox"/> HTN <input type="checkbox"/> MI <input type="checkbox"/> CHF <input type="checkbox"/> MVP/Murmur <input type="checkbox"/> Dysrhythmia <input type="checkbox"/> Angina <input type="checkbox"/> Previous Cardiac Workup Other/Comments _____
Respiratory	<input type="checkbox"/>	<input type="checkbox"/> Asthma <input type="checkbox"/> TB <input type="checkbox"/> COPD <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Chronic Cough <input type="checkbox"/> Home O2 <input type="checkbox"/> Sleep Apnea Other/Comments:_____
Gastrointestinal	<input type="checkbox"/>	<input type="checkbox"/> Cirrhosis <input type="checkbox"/> Reflux <input type="checkbox"/> Hiatal Hernia <input type="checkbox"/> Hepatitis <input type="checkbox"/> Ulcers <input type="checkbox"/> Esophageal Stricture Other/Comments:_____
Genitourinary/Renal:	<input type="checkbox"/>	<input type="checkbox"/> Stones <input type="checkbox"/> Dialysis <input type="checkbox"/> Renal Insufficiency Other/Comments:_____
Musculo/Skeletal	<input type="checkbox"/>	<input type="checkbox"/> Arthritis <input type="checkbox"/> Neck Problems <input type="checkbox"/> Back Problems Other/Comments:_____
Skin	<input type="checkbox"/>	<input type="checkbox"/> Rash <input type="checkbox"/> Jaundice <input type="checkbox"/> Cyanosis <input type="checkbox"/> Edema <input type="checkbox"/> Lesions Other/Comments:_____
Neurological	<input type="checkbox"/>	<input type="checkbox"/> Seizures <input type="checkbox"/> Stroke <input type="checkbox"/> Neuromuscular Disease <input type="checkbox"/> Weakness <input type="checkbox"/> Headaches Other Comments:_____
Psychiatric	<input type="checkbox"/>	<input type="checkbox"/> Depression/Bipolar <input type="checkbox"/> Hx of mental illness <input type="checkbox"/> Development Delay Other/Comments:_____
Endocrine/Diabetes	<input type="checkbox"/>	<input type="checkbox"/> Thyroid <input type="checkbox"/> Hypoglycemia <input type="checkbox"/> Steroid Use <input type="checkbox"/> Diabetes <input type="checkbox"/> Insulin Glucophage: <input type="checkbox"/> Y <input type="checkbox"/> N Other/Comments:_____
Hematologic/Lymphatic	<input type="checkbox"/>	<input type="checkbox"/> Clotting problems <input type="checkbox"/> ASA use <input type="checkbox"/> NSAIDS <input type="checkbox"/> Coumadin use <input type="checkbox"/> Blood Disease Other/Comments:_____