REVIEW OF SYSTEMS FORM

Patient Name: _____ *Date:* _____

- Mark all that apply
- Please CIRCLE the box stating *None* if it applies

Have you had any of the following *pulmonary (lung-related)* issues? ***None***

☐Asthma / Difficulty breathing ☐ COPD ☐Emphysema

☐Other:

Have you had any of the following *cardiovascular (heart-related)* issues or procedures? ***None***

☐Heart surgeries ☐Congestive Heart Failure ☐Pacemaker ☐Heart Attack / MI's ☐Heart Disease / Problems

☐Hypertension ☐Murmurs / Valvular Disease ☐Angina / Chest Pain ☐Irregular Heartbeat

☐Other:

Have you had any of the following *endocrine (glandular/hormonal-related)* issues or procedures? ***None***

☐Thyroid Disease ☐Hormone Replacement Therapy ☐Injectable Hormone Replacements ☐Diabetes

☐Other:

Have you had any of the following *renal (kidney-related)* issues or procedures? ***None***

☐Renal Calculi / Stones ☐Hematuria (blood in urine) ☐Incontinence (can't control) ☐Bladder Infections ☐Difficulty Urinating

☐Kidney Disease ☐Dialysis

☐Other:

Have you had any of the following *gastroenterological (stomach-related)* issues? ***None***

☐Nausea ☐Difficulty Swallowing ☐Ulcerative Disease ☐Frequent Abdominal pain ☐Hiatal Hernia

☐Constipation ☐Pancreatic Disease ☐Irritable Bowel/Colitis ☐Hepatitis or Liver Disease ☐Bloody or Black Tarry Stools

☐Vomiting Blood ☐Bowel incontinence ☐Gastroesophageal Reflux/Heartburn

☐Other:

Have you had any of the following *hematologic (blood-related)* issues? ***None***

☐Regular Anti-Inflammatory use (*Motrin/Ibuprofen/Naproxen/Naprosyn/Aleve*)

☐Hypercoagulation or Deep Venous Thrombosis/History of Blood Clots

☐Anemia ☐HIV Positive ☐Abnormal Bleeding/Bruising ☐Sickle-Cell Anemia ☐Enlarged Lymph Nodes

☐Hemophilia ☐Anticoagulant Therapy ☐Regular Aspirin Use

☐Other:

Have you had any of the following *dermatologic (skin-related)* issues? ***None***

☐Significant Burns ☐Significant Rashes ☐Skin Grafts ☐Psoriatic Disorders

☐Other:

Have you had any of the following *musculoskeletal (bone/muscle-related)* issues? ***None***

☐Rheumatoid Arthritis ☐Gout ☐Osteoarthritis ☐Broken Bones ☐Spinal Fracture

☐Spinal Surgery ☐Joint Surgery ☐Arthritis (unknown type) ☐Scoliosis ☐Metal Implants

☐Other:

Have you had any of the following *psychological* issues? ***None***

☐Psychiatric Diagnosis ☐Depression ☐Suicidal Ideations ☐Bipolar Disorder

☐Psychiatric Hospitalizations ☐Schizophrenia ☐Homicidal Ideations

☐Other:

Please write in this box anything else in your medical history that you feel is important and was not mentioned above.