Review of Systems: **Please answer the following questions regarding how you feel currently. Do you or have you recently had any of the following?**

EYES

Visual changes in the past year?	Yes	No
Glaucoma?	Yes	No
Double or blurred vision?	Yes	No
Pain, Redness or Dryness?	Yes	No

EARS

Do you currently wear hearing aids?	Yes	No
Date of purchase _______________		
Hearing Problems?	Yes	No
Ringing in the ears?	Yes	No
Discharge from the ears?	Yes	No
Loss of balance/vertigo?	Yes	No
Ear Pain?	Yes	No
Pressure in the ears?	Yes	No
Frequent ear infections?	Yes	No
History of loud noise exposure?	Yes	No

NOSE

Nasal congestion?	Yes	No
Nasal discharge?	Yes	No
Post nasal drip?	Yes	No
Loss of smell?	Yes	No
Frequent nose bleeds?	Yes	No
Snoring?	Yes	No
Injury to the nose?	Yes	No
Nasal or sinus surgery?	Yes	No
Frequent sinus infections?	Yes	No

THROAT

Sore throat?	Yes	No
Frequent throat infections?	Yes	No
Painful or difficulty swallowing?	Yes	No
Hoarseness?	Yes	No

HEART

Heart problems?	Yes	No
High blood pressure?	Yes	No
Angina/chest pain?	Yes	No
Swelling in the ankles?	Yes	No

CHEST

Asthma?	Yes	No
Bronchitis?	Yes	No
Shortness of breath?	Yes	No
Wheezing?	Yes	No
Chronic cough?	Yes	No
Cough blood?	Yes	No
History of Tuberculosis?	Yes	No

DIGESTIVE

Stomach problems?	Yes	No
Heartburn/ulcers?	Yes	No
Gallstones?	Yes	No
Vomited blood?	Yes	No
Chronic constipation/diarrhea?	Yes	No

DIGESTIVE, CONT.

Blood in the stools?	Yes	No
Liver problems?	Yes	No

GENITOURINARY

Kidney stone?	Yes	No
Frequent urination?	Yes	No
Bladder infections?	Yes	No
Painful urination?	Yes	No

INTEGUMENT

Previous skin cancer?	Yes	No
Changes to existing skin lesions?	Yes	No
Previous melanoma?	Yes	No
Changes to moles?	Yes	No
New skin lesions?	Yes	No
History of prolonged sun exposure?	Yes	No

NEUROLOGICAL

Frequent severe headaches?	Yes	No
Weakness/paralysis?	Yes	No
Tremors?	Yes	No
Convulsions/seizure?	Yes	No
Stroke?	Yes	No
Loss of consciousness?	Yes	No

MUSCULOSKELETAL

Severe back pain?	Yes	No
Joint pain?	Yes	No

ENDOCRINE

Heat intolerance?	Yes	No
Excessive sweating?	Yes	No
Thyroid condition?	Yes	No
Diabetes?	Yes	No
Hypoglycemic?	Yes	No
Hyperglycemic?	Yes	No

PSYCHIATRIC

Difficulty sleeping?	Yes	No
Difficulty staying asleep?	Yes	No
Excessive daytime sleepiness?	Yes	No

BLOOD

Anemia?	Yes	No
Easy bruising?	Yes	No
Received transfusions?	Yes	No

Office Use Only

Height ___________

Weight ___________

B/P ___________

Temp ___________

Pulse ___________

The above information is true and correct to the best of my knowledge.

Signed ____ Date ______________________