

Date:	Name:	
	DOB:	Age:

Medical History: Review of Systems

(Please indicate if any of the following medical conditions pertain to you)					
Eyes: glaucoma cataract macular degeneration inflammation vision disturbances blurry vision dry or watery eyes infections other	Yes ☐ √ ☐ ☐ ☐ ☐ ☐ ☐ ☐	No ☐	Constitutional: development disability unintended weight loss persistant fever chronic fatigue trauma other	Yes ☐ √ ☐ ☐ ☐ ☐	No ☐
Cardiovascular: heart disease high blood pressure stroke vascular disease other	Yes ☐ √ ☐ ☐ ☐ ☐	No ☐	Musculoskeletal: muscle/joint pain muscle spasms muscle weakness muscle/joint swelling arthritis other	Yes ☐ √ ☐ ☐ ☐ ☐	No ☐
Endocrine: diabetes hormonal dysfunction cholesterol/lipid problems cancer other	Yes ☐ √ ☐ ☐ ☐ ☐	No ☐	Gastrointestinal: diarrhea/contispation vomiting heartburn/ ulcer cancer other	Yes ☐ √ ☐ ☐ ☐ ☐	No ☐
Respiratory: emphysema pneumonia asthma bronchitis/cough cancer other	Yes ☐ √ ☐ ☐ ☐ ☐ ☐	No ☐	Allergic/Immunologic allergies rheumatoid arthritis lupus autoimmune disease other	Yes ☐ √ ☐ ☐ ☐ ☐	No ☐
Blood/Lymphatic: anemia bleeding problems leukemia other	Yes ☐ √ ☐ ☐ ☐	No ☐	Integumentary (skin): eczema/dermatitis rosacea/acne/psoriasis cysts/warts/ulcer cancer other	Yes ☐ √ ☐ ☐ ☐ ☐	No ☐
Nervous System: seizures multiple sclerosis head-aches/migraines paralysis numbness/ cold other	Yes ☐ √ ☐ ☐ ☐ ☐ ☐	No ☐	Mental: depression panic/anxiety disorders mood changes psychoses amnesia/sleep disorders other	Yes ☐ √ ☐ ☐ ☐ ☐ ☐	No ☐
Ears/Nose/Throat runny nose/ hay fever sinus congestion dry mouth/throat cancer other	Yes ☐ √ ☐ ☐ ☐ ☐	No ☐	Genitourinary: genital/prostate kidney/bladder overy/uterus/vaginal cancer other	Yes ☐ √ ☐ ☐ ☐ ☐	No ☐