

Review Of Systems: (Check all that apply)

Skin:

- | | | | | | |
|---|------------------------------------|---|------------------------------------|--|---|
| <input type="checkbox"/> acne | <input type="checkbox"/> dry | <input type="checkbox"/> liver spots | <input type="checkbox"/> rash | <input type="checkbox"/> white bumps | <input type="checkbox"/> ridged nails |
| <input type="checkbox"/> athlete's foot | <input type="checkbox"/> eczema | <input type="checkbox"/> oily | <input type="checkbox"/> redness | <input type="checkbox"/> white patches | <input type="checkbox"/> spoon shaped nails |
| <input type="checkbox"/> bruising | <input type="checkbox"/> hair loss | <input type="checkbox"/> pale | <input type="checkbox"/> rough | <input type="checkbox"/> yellow tone | <input type="checkbox"/> white spots on nails |
| <input type="checkbox"/> burning feet | <input type="checkbox"/> herpes | <input type="checkbox"/> peeling | <input type="checkbox"/> skin tags | <input type="checkbox"/> bluish lips | |
| <input type="checkbox"/> cracks | <input type="checkbox"/> hives | <input type="checkbox"/> poor wound healing | <input type="checkbox"/> vitiligo | <input type="checkbox"/> deep red lips | |
| <input type="checkbox"/> dandruff | <input type="checkbox"/> itching | <input type="checkbox"/> psoriasis | <input type="checkbox"/> warts | <input type="checkbox"/> pale lips | |

Eyes:

- | | | | | | | |
|---|---------------------------------------|------------------------------------|--|--|---------------------------------------|---------------------------------------|
| <input type="checkbox"/> bags under | <input type="checkbox"/> cataracts | <input type="checkbox"/> diplopia | <input type="checkbox"/> floaters | <input type="checkbox"/> light sensitive | <input type="checkbox"/> sclera blue | <input type="checkbox"/> swollen lids |
| <input type="checkbox"/> blurred vision | <input type="checkbox"/> crusty lids | <input type="checkbox"/> discharge | <input type="checkbox"/> freq blinking | <input type="checkbox"/> pain | <input type="checkbox"/> sclera white | <input type="checkbox"/> tearing |
| <input type="checkbox"/> burning | <input type="checkbox"/> dark circles | <input type="checkbox"/> dyslexia | <input type="checkbox"/> glaucoma | <input type="checkbox"/> bloodshot | <input type="checkbox"/> styes | |

Ears:

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|------------------------------------|--|------------------------------------|--|--|-----------------------------------|
| <input type="checkbox"/> discharge | <input type="checkbox"/> excessive wax | <input type="checkbox"/> infection | <input type="checkbox"/> red ear lobes | <input type="checkbox"/> sound sensitive | <input type="checkbox"/> vertigo |
| <input type="checkbox"/> earaches | <input type="checkbox"/> hearing loss | <input type="checkbox"/> itching | <input type="checkbox"/> ringing | <input type="checkbox"/> tinnitus | <input type="checkbox"/> pressure |

Nose & Sinuses:

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|------------------------------------|-------------------------------------|---------------------------------------|--------------------------------------|--|-------------------------------------|
| <input type="checkbox"/> crusts | <input type="checkbox"/> freq colds | <input type="checkbox"/> itching | <input type="checkbox"/> nose bleeds | <input type="checkbox"/> sinus trouble | <input type="checkbox"/> stuffiness |
| <input type="checkbox"/> discharge | <input type="checkbox"/> hayfever | <input type="checkbox"/> mucus yellow | <input type="checkbox"/> polyps | <input type="checkbox"/> sneezing | <input type="checkbox"/> asthma hx |

Mouth & Throat:

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|--|--|--|--|--------------------------------------|--|---|
| <input type="checkbox"/> amalgams | <input type="checkbox"/> canker sores | <input type="checkbox"/> silver fillings | <input type="checkbox"/> gag easily | <input type="checkbox"/> grind teeth | <input type="checkbox"/> lines on tongue | <input type="checkbox"/> mouth ulcers |
| <input type="checkbox"/> bad breath | <input type="checkbox"/> chapped lips | <input type="checkbox"/> dentures | <input type="checkbox"/> gingivitis | <input type="checkbox"/> hoarseness | <input type="checkbox"/> lips crack | <input type="checkbox"/> red tip tongue |
| <input type="checkbox"/> bleeding gums | <input type="checkbox"/> coated tongue | <input type="checkbox"/> drooling | <input type="checkbox"/> glossy tongue | <input type="checkbox"/> implants | <input type="checkbox"/> magenta tongue | <input type="checkbox"/> root canals |
| <input type="checkbox"/> bridges | <input type="checkbox"/> crowns | <input type="checkbox"/> freq sore throats | <input type="checkbox"/> gold fillings | <input type="checkbox"/> infections | <input type="checkbox"/> metal braces | <input type="checkbox"/> sore tongue |

Respiratory:

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|---------------------------------|-------------------------------------|---|------------------------------------|--|--|
| <input type="checkbox"/> apnea | <input type="checkbox"/> bronchitis | <input type="checkbox"/> cough | <input type="checkbox"/> pleurisy | <input type="checkbox"/> shortness in breath | <input type="checkbox"/> Smoke: Y Or N Pack per day ____ |
| <input type="checkbox"/> asthma | <input type="checkbox"/> congestion | <input type="checkbox"/> difficulty breathing | <input type="checkbox"/> pneumonia | <input type="checkbox"/> wheeze | |

Cardiac:

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|---|----------------------------------|---|-----------------------------------|---------------------------------------|---|
| <input type="checkbox"/> cold extremities | <input type="checkbox"/> dyspnea | <input type="checkbox"/> flushing Of skin | <input type="checkbox"/> high B/P | <input type="checkbox"/> palpitations | <input type="checkbox"/> Atherosclerosis: Y Or N |
| <input type="checkbox"/> chest pain | <input type="checkbox"/> edema | <input type="checkbox"/> heart murmurs | <input type="checkbox"/> low B/P | <input type="checkbox"/> tight chest | <input type="checkbox"/> Hx Of Heart Surgery ____ |

Gastrointestinal:

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|---|---------------------------------------|--|---|--|--|--|
| <input type="checkbox"/> abdominal pain | <input type="checkbox"/> bloating | <input type="checkbox"/> diarrhea | <input type="checkbox"/> gall bladder trouble | <input type="checkbox"/> indigestion | <input type="checkbox"/> nausea | <input type="checkbox"/> ulcers |
| <input type="checkbox"/> anal itching | <input type="checkbox"/> colitis | <input type="checkbox"/> difficulty swallowing | <input type="checkbox"/> heartburn | <input type="checkbox"/> irritable bowel | <input type="checkbox"/> regurgitation | <input type="checkbox"/> vomiting |
| <input type="checkbox"/> belching | <input type="checkbox"/> constipation | <input type="checkbox"/> flatulence | <input type="checkbox"/> hemorrhoids | <input type="checkbox"/> mucus | <input type="checkbox"/> tan stool | <input type="checkbox"/> fat intolerance |

Urinary:

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|-----------------------------------|------------------------------------|---------------------------------------|---|-----------------------------------|-------------------------------------|--|
| <input type="checkbox"/> burning | <input type="checkbox"/> frequency | <input type="checkbox"/> incontinence | <input type="checkbox"/> kidney disease | <input type="checkbox"/> polyuria | <input type="checkbox"/> urgency | <input type="checkbox"/> dark yellow urine |
| <input type="checkbox"/> cystitis | <input type="checkbox"/> hesitancy | <input type="checkbox"/> infections | <input type="checkbox"/> nocturia | <input type="checkbox"/> stones | <input type="checkbox"/> pale urine | <input type="checkbox"/> pale urine |

Genital (male):

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|---|--------------------------------------|--|--|--|
| <input type="checkbox"/> discharge | <input type="checkbox"/> impotence | <input type="checkbox"/> itching | <input type="checkbox"/> prostatic hypertrophy | <input type="checkbox"/> testicular pain |
| <input type="checkbox"/> genital herpes | <input type="checkbox"/> infertility | <input type="checkbox"/> painful urination | <input type="checkbox"/> sores | <input type="checkbox"/> infection |

Genital (female):

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|--|---|---|--|--|---|
| <input type="checkbox"/> birth control pills | <input type="checkbox"/> endometriosis | <input type="checkbox"/> genital herpes | <input type="checkbox"/> infertility | <input type="checkbox"/> menopausal symptoms | <input type="checkbox"/> tender breasts |
| <input type="checkbox"/> discharge | <input type="checkbox"/> excess hair growth | <input type="checkbox"/> hot flashes | <input type="checkbox"/> irregular cycle | <input type="checkbox"/> PMS | <input type="checkbox"/> yeast infections |
| <input type="checkbox"/> dysmenorrhea | <input type="checkbox"/> rigidity | <input type="checkbox"/> hysterectomy | <input type="checkbox"/> itching | <input type="checkbox"/> spotting | <input type="checkbox"/> excessive bleeding |

Musculoskeletal:

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|------------------------------------|---------------------------------------|--|---|--|--|
| <input type="checkbox"/> arthritis | <input type="checkbox"/> CP | <input type="checkbox"/> hx Of fractures | <input type="checkbox"/> joint swelling | <input type="checkbox"/> muscle weakness | <input type="checkbox"/> spasticity |
| <input type="checkbox"/> atrophy | <input type="checkbox"/> fibromyalgia | <input type="checkbox"/> hypotonia | <input type="checkbox"/> limited range/motion | <input type="checkbox"/> rigidity | <input type="checkbox"/> stiffness |
| <input type="checkbox"/> backache | <input type="checkbox"/> gout | <input type="checkbox"/> joint pain | <input type="checkbox"/> muscle pain | <input type="checkbox"/> spasms | <input type="checkbox"/> uneven muscular development |

Neurologic:

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|--|---|--|--|--|--|--|
| <input type="checkbox"/> abnormal gait | <input type="checkbox"/> confusion | <input type="checkbox"/> headaches | <input type="checkbox"/> learning problems | <input type="checkbox"/> poor dream recall | <input type="checkbox"/> shaky feeling | <input type="checkbox"/> unprovoked anger |
| <input type="checkbox"/> ADD | <input type="checkbox"/> delusional | <input type="checkbox"/> hyperactivity | <input type="checkbox"/> mood swings | <input type="checkbox"/> poor memory | <input type="checkbox"/> speech delay | <input type="checkbox"/> weakness |
| <input type="checkbox"/> ADHD | <input type="checkbox"/> depression | <input type="checkbox"/> impulsiveness | <input type="checkbox"/> nervousness | <input type="checkbox"/> rage behavior | <input type="checkbox"/> tension | <input type="checkbox"/> withdrawal |
| <input type="checkbox"/> anxiety | <input type="checkbox"/> disoriented | <input type="checkbox"/> insomnia | <input type="checkbox"/> nightmares | <input type="checkbox"/> restlessness | <input type="checkbox"/> tics | <input type="checkbox"/> autistic features |
| <input type="checkbox"/> apathy | <input type="checkbox"/> excessive sleepiness | <input type="checkbox"/> irritable | <input type="checkbox"/> numbness | <input type="checkbox"/> sciatica | <input type="checkbox"/> tingling | |
| <input type="checkbox"/> brain fog | <input type="checkbox"/> fainting | <input type="checkbox"/> poor coordination | <input type="checkbox"/> PDD | <input type="checkbox"/> seizures | <input type="checkbox"/> tremors | |

Endocrine:

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|---|---|---|---------------------------------------|--|--------------------------------------|
| <input type="checkbox"/> coarse features | <input type="checkbox"/> edema | <input type="checkbox"/> excessive thirst | <input type="checkbox"/> HRT | <input type="checkbox"/> hypothyroid | <input type="checkbox"/> underweight |
| <input type="checkbox"/> cold intolerance | <input type="checkbox"/> excessive hunger | <input type="checkbox"/> fatigue | <input type="checkbox"/> hyperthyroid | <input type="checkbox"/> poor carb tolerance | <input type="checkbox"/> diabetes hx |
| <input type="checkbox"/> dysinsulism | <input type="checkbox"/> excessive sweating | <input type="checkbox"/> heat intolerance | <input type="checkbox"/> hypoglycemia | <input type="checkbox"/> overweight | |

Immune:

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|---|--|---|--|--|
| <input type="checkbox"/> autoimmune | <input type="checkbox"/> cancer hx | <input type="checkbox"/> hepatitis hx | <input type="checkbox"/> lupus | <input type="checkbox"/> recurrent illness |
| <input type="checkbox"/> breast implants | <input type="checkbox"/> chronic fatigue | <input type="checkbox"/> infections | <input type="checkbox"/> Lyme's | <input type="checkbox"/> swollen glands |
| <input type="checkbox"/> allergic To everything | <input type="checkbox"/> CFS Hx | <input type="checkbox"/> chemical intolerance | <input type="checkbox"/> dental implants | <input type="checkbox"/> universal reactor |