

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:

<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:

<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:

<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:

<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:

<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:

<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:

<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):

<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):

<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:

<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:

<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:

<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:

<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