

Medical History Form - Review of Systems:

Do you have any of the following? (Please circle. If you answer yes, please explain.)

System	Yes or No	Not sure	Explain/Medications
I. Integumentary (skin) conditions	Y / N	?	_____
II. Neurologic			
1. Headaches/Migraine	Y / N	?	_____
2. Seizures	Y / N	?	_____
III. Eyes			
1. Loss of Vision	Y / N	?	_____
2. Double Vision	Y / N	?	_____
3. "Pink"/ Red Eye	Y / N	?	_____
4. Light Sensitive	Y / N	?	_____
5. Eye Pain	Y / N	?	_____
6. Eye infections	Y / N	?	_____
7. Eye Diseases	Y / N	?	_____
8. Watery Eyes	Y / N	?	_____
9. Dry Eyes	Y / N	?	_____
IV. Ears, Nose, Mouth, Throat			
1. Allergies	Y / N	?	_____
2. Hay Fever	Y / N	?	_____
3. Sinus Congestion	Y / N	?	_____
4. Runny Nose	Y / N	?	_____
5. Dry Throat/Mouth	Y / N	?	_____
6. Ear Infection	Y / N	?	_____
V. Respiratory			
1. Asthma	Y / N	?	_____
2. Chronic Bronchitis	Y / N	?	_____
3. Emphysema	Y / N	?	_____
VI. Vascular			
1. High Blood Pressure	Y / N	?	_____
2. Vascular Disease	Y / N	?	_____
VII. Gastrointestinal			
1. Diarrhea	Y / N	?	_____
2. Constipation	Y / N	?	_____
VIII. Genitourinary			
1. Genitals	Y / N	?	_____
2. Kidney/Bladder	Y / N	?	_____
IX. Bones/Joints/Muscles			
1. Rheumatoid Arthritis	Y / N	?	_____
2. Muscle/joint Pain	Y / N	?	_____
X. Lymphatic/Hematological			
1. Anemia	Y / N	?	_____
2. Bleeding Problems	Y / N	?	_____
XI. Endocrine			
1. Diabetes	Y / N	?	_____
2. Thyroid/other	Y / N	?	_____
XII. Psychiatric			
1. Anxiety/ depression	Y / N	?	_____
XIII. Constitutional			
1. Fever	Y / N	?	_____