

REVIEW OF SYSTEMS:

NAME _____ DATE _____

PLEASE ANSWER ALL OF THE QUESTIONS BELOW. PLEASE GIVE DETAILS OF ALL MARKED ITEMS.

FEVER	<input type="checkbox"/> N	
WEIGHT LOSS <input type="checkbox"/> INTENTIONAL <input type="checkbox"/> UNINTENTIONAL	<input type="checkbox"/> N	
EYE PROBLEMS <input type="checkbox"/> GLAUCOMA <input type="checkbox"/> BLINDNESS	<input type="checkbox"/> N	
EAR NOSE MOUTH THROAT	<input type="checkbox"/> N	
CARDIOVASCULAR PROBLEMS <input type="checkbox"/> HYPERTENSION <input type="checkbox"/> HEART ATTACK <input type="checkbox"/> CHEST PAIN <input type="checkbox"/> PALPITATIONS <input type="checkbox"/> IRREGULAR BEAT <input type="checkbox"/> CLAUDICATION	<input type="checkbox"/> N	
RESPIRATORY PROBLEMS <input type="checkbox"/> ASTHMA <input type="checkbox"/> DYSPNEA <input type="checkbox"/> EMPHYSEMA <input type="checkbox"/> BRONCHITIS	<input type="checkbox"/> N	
GASTROINTESTINAL PROBLEMS <input type="checkbox"/> CHANGE IN HABITS <input type="checkbox"/> DIARRHEA <input type="checkbox"/> CONSTIPATION <input type="checkbox"/> MELENA <input type="checkbox"/> HEMATOCHESIA <input type="checkbox"/> SATIETY <input type="checkbox"/> JAUNDICE <input type="checkbox"/> ABDOMINAL PAIN	<input type="checkbox"/> N	
ENDOCRINE PROBLEMS <input type="checkbox"/> DIABETES <input type="checkbox"/> THYROID <input type="checkbox"/> VASCULITIS	<input type="checkbox"/> N	
HEMATOLOGICAL PROBLEMS <input type="checkbox"/> BLOOD CLOTS <input type="checkbox"/> BLEEDING <input type="checkbox"/> ANEMIA	<input type="checkbox"/> N	
NEUROLOGICAL PROBLEMS <input type="checkbox"/> STROKE <input type="checkbox"/> TIA <input type="checkbox"/> PARALYSIS/WEAKNESS <input type="checkbox"/> PARKINSONS <input type="checkbox"/> MS	<input type="checkbox"/> N	
SKIN PROBLEMS <input type="checkbox"/> CANCER <input type="checkbox"/> RASH	<input type="checkbox"/> N	
INFECTIONS <input type="checkbox"/> STD <input type="checkbox"/> HIV <input type="checkbox"/> HEPATITIS <input type="checkbox"/> PNEUMONIA <input type="checkbox"/> TB <input type="checkbox"/> UTI/KIDNEY <input type="checkbox"/> DIVERTICULITIS	<input type="checkbox"/> N	