Patient Information Form
Part 2 REVIEW OF SYSTEMS

Please print before filling in.
This is a confidential record and will be kept in your doctor's office and will not be released to anyone without your prior authorization.

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DO YOU NOW OR HAVE YOU HAD ANY PROBLEMS RELATED TO THE FOLLOWING SYSTEMS: (PLEASE EXPLAIN ANY YES ANSWERS IN THE SPACE PROVIDED.)

Please answer:	Yes	No	Please answer:	Yes	No	Please answer:	Yes	No
CONSTITUTIONAL SYMPTOMS			INTEGUMENTARY SYMPTOMS			ENDOCRINE		
FEVER			SKIN RASH			EXCESSIVE THIRST		
CHILLS			BOILS			TOO HOT/COLD		
HEADACHE			PERSISTENT ITCH			TIRED/SLUGGISH		
OTHER			OTHER			OTHER		
EYES			MUSCULOSKELETAL			RESPIRATORY		
BLURRED VISION			JOINT PAIN			SHORTNESS IN BREATH		
DOUBLE VISION			NECK PAIN			WHEEZING		
PAIN			BACK PAIN			FREQUENT COUGH		
OTHER			OTHER			OTHER		
ALLERGIC/IMMUNOLOGIC			EAR/NOSE/THROAT/MOUTH			HEMATOLOGICAL/LYMPATIC		
HAY FEVER			EAR INFECTION			SWOLLEN GLANDS		
DRUG ALLERGIES			SORE THROAT			BLOOD CLOTS		
OTHER			OTHER			OTHER		
NEUROLOGICAL			GENITOURINARY			CARDIOVASCULAR		
TREMORS			URINARY RETENTION			CHEST PAIN		
DIZZY SPELLS			PAINFUL URINATION			VARICOSE VEINS		
NUMBNESS/TINGLING			URINARY FREQUENCY			HIGH BLOOD PRESSURE		
OTHER			OTHER			OTHER		
GASTROINTESTINAL			PSYCHOLOGIC					
ABDOMINAL PAIN			ARE YOU SATISFIED WITH YOUR LIFE?					
NAUSEA/VOMITING			ARE YOU DEPRESSED?					
INDIGESTION/HEARTBURN			HAVE YOU CONSIDERED SUICIDE?					
OTHER			OTHER					