REVIEW OF SYSTEMS

FULL NAME_____ DATE_____
AGE_____RACE_____GENDER_____HEIGHT_____WEIGHT_____

IF CHECK YES – PLEASE EXPLAIN:
Be sure to list all conditions or symptoms, both past and present.

1. Do you have skin, hair or nail problems?
   □ No □ **Yes**_____
2. Do you have mouth and/or throat problems?
   □ No □ **Yes**_____
3. Do you have nose and/or sinus problems?
   □ No □ **Yes**_____
4. Do you have ear problems?
   □ No □ **Yes**_____
5. Do you have eye problems?
   □ No □ **Yes**_____
6. Do you have chest or lung (breathing) problems?
   □ No □ **Yes**_____
7. Do you have heart and/or blood vessel problems?
   □ No □ **Yes**_____
8. Do you have blood or lymph node problems?
   □ No □ **Yes**_____
9. Do you have digestive problems?
   □ No □ **Yes**_____
10. Do you have genital problems (e.g. prostate, testicular, vaginal)?
    □ No □ **Yes**_____
11. Do you have urinary (including kidney or bladder) problems?
    □ No □ **Yes**_____
12. Do you have any nervous system diseases and/or mental health problems?
    □ No □ **Yes**_____
13. Do you have any gland and/or hormone problems?
    □ No □ **Yes**_____
14. Do you have any allergy or immunity problems?
    □ No □ **Yes**_____
15. Do you have any muscle, tendon or ligament problems?
    □ No □ **Yes**_____
16. Do you have any bone or joint diseases (e.g. osteoporosis, arthritis)?
    □ No □ **Yes**_____
17. **Women only:**
    a. Do you have menstrual problems?
       □ No □**Yes**_____
    b. Do you have any breast problems?
       □ No □**Yes**_____