

Review of Systems

Please indicate if you have never experienced (=N), previously experienced (=P), or are currently experiencing (=C) any of the following symptoms:

GENERAL	Difficulty breathing/	Painful urination
Allergies	shortness of breath	Urinary hesitancy
Chills	Pain on breathing	
Convulsions	Chronic cough	FEMALE
 Dizziness	Wheezing	Menstrual cramps
Fainting	Asthma	Heavy menstrual flow
Fatigue	Spitting up blood	Irregular menstrual flow
Headache	Excessive phlegm	Spotting
Loss of sleep		Lumps in breast
Weight loss	MUSCLES & JOINTS	Breast pain/tenderness
Weight gain	Arthritis	Vaginal discharge
Nervousness	Bursitis	Sexual difficulty
Depression	Low back pain	<pre>Pain during intercourse</pre>
Nerve pain/changes in	Neck pain/stiffness	Birth control use
sensation	Shoulder pain	Hot flashes
Sweats	Knee pain	Pregnancy,
Tremors		# of pregnancies
Swelling	EYES, EARS, NOSE, THROAT	# ofbirths
	Frequent colds/flu	# of children
DIGESTIVE	Dental decay	
Belching	Ear discharge	MALE
Colitis	Ear pain	Testicular pain
Constipation	Ringing in the ears	Testicular masses
Diarrhea	Hearing difficulty	Sexual difficulty
Bloody stools	Enlarged glands	
Bloating	Enlarged thyroid	
Abdominal pain	Voice change	
Excessive gas	Eye pain	
Heart burn	Eyesight changes	
Hemorrhoids	Sinus infection	
Vomiting	Tonsillitis	
Nausea		
Poor appetite	SKIN	
Excessive hunger	Easy bruising	
	Dryness	
CARDIOVASCULAR	Rash	
High blood pressure	Itching	
Low blood pressure	Varicose veins	
High cholesterol		
Chest pain	URINARY	
Poor circulation	Bed-wetting	
Rapid heart beat	Blood in urine	
DECDIDATORY	Frequent urination	
RESPIRATORY	<pre>Frequent urination at night</pre>	