

Review of Systems

Have you ever had problems with your:

	Circle one		Describe all your "YES" responses
Eyes	YES	NO	_____
Ears, Nose, Throat	YES	NO	_____
Digestive problems	YES	NO	_____
Bladder or Prostate problems	YES	NO	_____
Diabetes	YES	NO	_____
High blood pressure	YES	NO	_____
Heart disease	YES	NO	_____
High cholesterol	YES	NO	_____
Kidney disease	YES	NO	_____
Bleeding disorder	YES	NO	_____
Hepatitis or liver disease	YES	NO	_____
Depression	YES	NO	_____
Cancer	YES	NO	_____
Arthritis	YES	NO	_____
Lungs or breathing problems	YES	NO	_____
Neurologic disease	YES	NO	_____
Thyroid disease	YES	NO	_____
HIV/AIDS	YES	NO	_____
Blood clots	YES	NO	_____
Stroke	YES	NO	_____

Family History

Significant Family History: _____

Social History

____ Employed: (occupation) _____

____ Student ____ Retired ____ Unemployed

____ Single ____ Married ____ Divorced ____ Widowed

Children? YES NO

Currently smoke? YES NO If Yes, ____ packs per day

Alcohol consumption: NEVER DAILY 1-2 TIMES A WEEK RARELY

Patient Signature: _____ Date: _____

Reviewed by: _____ Date: _____