REVIEW OF SYSTEMS

Check your current symptoms, and also check those symptoms you have had in the past.

HEAD	Now	Past
Headaches	☐	☐
Injuries	☐	☐
Bumps	☐	☐
Last Eye Exam	☐	☐
Glasses	☐	☐
Contacts	☐	☐
Cataracts	☐	☐

NECK	Now	Past
Neck Enlargement	☐	☐
Stiff Neck	☐	☐
Soreness	☐	☐
Lumps	☐	☐
Masses	☐	☐

MUSCULOSKELETAL	Now	Past
Muscle Pain	☐	☐
Muscle Weakness	☐	☐
Muscle Cramps	☐	☐
Muscle Twitching	☐	☐
Joint Stiffness	☐	☐
Joint Pain	☐	☐

I have not had any of these symptoms. ☐

NEUROLOGIC	Now	Past		Now	Past
Seizures	☐	☐	Loss of Facial	☐	☐
Vertigo	☐	☐	Weak Grip	☐	☐
Dizziness	☐	☐	Paralysis	☐	☐
Hand Trembling	☐	☐	Difficulty Speech	☐	☐
Loss of Sensation	☐	☐	Tingling	☐	☐
Incoordination	☐	☐	Numbness	☐	☐
Loss of Memory	☐	☐		☐	☐

PAST MEDICAL HISTORY

Check only the conditions you have had in the past. None pertain to me. ☐

	Yes
Arthritis	☐
Broken Bones	☐
Depression	☐
Epilepsy	☐
Spinal Conditions	☐
Hepititis	☐
Jaw Pain	☐
Multiple Sclerosis	☐
Polio	☐
Stroke/Heart Attack	☐
Allergies	☐
Ulcers	☐
Hip Pain	☐

	Yes
Asthma	☐
Cancer	☐
Diabetes	☐
Eye/Vision Problems	☐
Headaches	☐
High Blood Pressure	☐
Menstrual Problems	☐
Neurologica Prob.	☐
Prostate Problems	☐
Varicose Veins	☐
Tumor	☐
Mental Illness	☐
Elbow Pain	☐
Knee Pain	☐

	Yes
Back Pain	☐
Chest Pain	☐
Dizziness	☐
Fainting	☐
Hearing Problems	☐
HIV	☐
Heart Problems	☐
Pacemaker	☐
Weight Change	☐
Gallstones	☐
Joint Pain	☐
Pain	☐
Pain	☐
	☐

SOCIAL HISTORY

Circle the correct answer or fill in the blank

Current Weight_____ Have you recently lost or gained weight?_____

Mental Work Heavy Moderate Light Hours per day? _____

Physical Work Heavy Moderate Light Hours per day? _____

Exercise None Heavy Moderate Light Hours per day? _____ Type_____

Smoking Never Current Previous Pack per day _____ No. of years_____

Alcohol None Beer/Wk _____ Liquor/wk _____ Wine/wk _____ No of years_____

Caffeine (Coffee,Tea,Cola) Cups/Day _____ No. of Years _____

Aspirin No./Day _____ No. of years _____ Others _____

Patient's Signature _____ Date _____