

| REVIEW OF SYSTEMS | YES | NO | <i>For Physician Use Only</i> |
|--|------------|-----------|--------------------------------------|
| CONSTITUTIONAL | **** | **** | |
| Have you had problems with fever, chills, night sweats, or unintentional weight loss? | | | |
| EYES | **** | **** | |
| Do you wear glasses? | | | |
| Do you have Glaucoma? | | | |
| ENT & MOUTH | **** | **** | |
| Do you suffer from hearing loss? | | | |
| Have you had recent problems with nose bleeds or hoarseness? | | | |
| VASCULAR | **** | **** | |
| Have you ever had a vein-stripping? | | | |
| Do your legs hurt during activity? | | | |
| RESPIRATORY | **** | **** | |
| Do you have an unexplained cough or blood in your sputum? | | | |
| Do you snore loudly? | | | |
| GASTROINTESTINAL | **** | **** | |
| Have you recently had problems with nausea, vomiting abdominal pain, constipation, or diarrhea? | | | |
| Do you have peptic ulcer disease? | | | |
| Have you noticed blood in your stools? | | | |
| GENITOURINARY | **** | **** | |
| Have you noticed blood in your urine? | | | |
| Have you ever had a kidney stone? | | | |
| Do you use Viagra? | | | |
| NEUROLOGICAL | **** | **** | |
| Have you ever experienced one-sided weakness or sensory loss, severe headaches, blurred vision, transient blindness, severe dizziness, or loss of consciousness? | | | |
| ENDOCRINE | **** | **** | |
| Do you have trouble with frequent urination, excessive water consumption, or an excessive appetite? | | | |
| Have you ever taken a "Diet Pill"? | | | |
| HEMATOLOGIC/LYMPHATIC | **** | **** | |
| Do you bruise or bleed easily? | | | |
| Have you received a blood transfusion in the past? | | | |
| Have you ever seen a blood specialist? | | | |

Patient Name: _____ **Date:** _____