**MEDICAL REVIEW OF SYSTEMS**

**Constitutional Neurology**

Weight Gain O Yes O No Headache O Yes O No

Weight Loss O Yes O No Seizures O Yes O No

Obesity O Yes O No Weakness O Yes O No

Cold Limbs (Feet/Hands) O Yes O No Tremor O Yes O No

Gait difficulties O Yes O No

**Cardiology**

Chest Pain O Yes O No **Psychology**

Palpitations O Yes O No Depression O Yes O No

Hypertension O Yes O No Anxiety O Yes O No

Heart Attack (MI) O Yes O No Panic attacks O Yes O No

Congestive Heart Failure O Yes O No Nervousness O Yes O No

Pacemaker O Yes O No

Murmurs O Yes O No

**Endocrinology**

Excessive sweating O Yes O No

**Respiratory** Excessive Thirst O Yes O No

Problems with Anesthesia O Yes O No

Wheezing O Yes O No

Nasal Stuffiness O Yes O No **Hematology/Lymph**

Shortness of breath O Yes O No Swollen Glands O Yes O No

Emphysema O Yes O No Fevers O Yes O No

Abnormal bleeding O Yes O No

Abnormal Bruising O Yes O No

**Gastroenterology**

Abdominal Pain O Yes O No **Other Current Medical Conditions:**

Heartburn O Yes O No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Ulcer O Yes O No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Musculoskeletal**

Joint Pain O Yes O No **Past Surgeries & Dates:**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Joint Stiffness O Yes O No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Arthritis O Yes O No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sprains/Strains O Yes O No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Fracture O Yes O No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Name:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date of Birth:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Physician Review:** \_\_\_\_\_\_\_\_\_\_\_\_\_

**Integumentary**

Rash O Yes O No

Lumps O Yes O No

Bruising O Yes O No

Skin Cancer O Yes O No