Review of Systems

Do you now or have you had any problems related to the following systems? Circle **Y**es or **N**o.

CONSTITUTIONAL SYMPTOMS

Fever	Y	N
Chills	Y	N
Headache	Y	N
Change in appetite, wt, energy	Y	N

Other _____

EYES

Blurred vision	Y	N
Double vision	Y	N
Pain	Y	N

Other _____

ALLERGIC/IMMUNOLOGIC

Hay Fever	Y	N
Food allergies	Y	N

Other _____

NEUROLOGICAL

Tremors	Y	N
Dizzy spells	Y	N
Numbness/Tingling	Y	N
Seizures	Y	N

Other _____

ENDOCRINE

Excessive thirst	Y	N
Too hot/cold	Y	N
Tired/sluggish	Y	N

Other _____

GASTROINTESTINAL

Abdominal pain	Y	N
Nausea/vomiting	Y	N
Indigestion/heartburn	Y	N
Change stool size/shape/color	Y	N
Pain with swallowing	Y	N

Other _____

CARDIOVASCULAR

Chest pain	Y	N
rapid heart rate	Y	N
High blood pressure	Y	N

Other _____

INTEGUMENTARY

Skin rash	Y	N
Boils	Y	N
Persistent itch	Y	N

Other _____

MUSCULOSKELETAL

Neck pain	Y	N
Joint swelling/pain	Y	N
Back pain	Y	N
Bone pain	Y	N

Other _____

EAR/NOSE/THROAT/MOUTH

Ear infection	Y	N
Sinus problem	Y	N
Bleeding from ears, nose, gums	Y	N

Other _____

GENITOURINARY

Urine retention	Y	N
Painful urination	Y	N
Urinary frequency	Y	N
Change in urine stream	Y	N

Other _____

RESPIRATORY

Wheezing	Y	N
Frequent cough	Y	N
Shortness of breath	Y	N

Other _____

Hematologic/Lymphatic

Swollen glands	Y	N
Blood clotting problem	Y	N
Prior blood transfusions	Y	N

Other _____

PSYCHOLOGIC

Are you generally satisfied with your life:	Y	N
Do you feel severely depressed?	Y	N
Have you considered suicide?	Y	N

Other _____

IF YOU ARE PREGNANT OR HAVE REASON TO BELIEVE YOU MAY BE PREGNANT, PLEASE NOTIFY THE MEDICAL ASSISTANT AND THE X-RAY TECHNOLOGIST.