Review of Systems *Life Enhancement Clinic, PC*

Patient Name _____ Date _____

Please check whether you are currently dealing with, have dealt with in the past, or have never had the following conditions.

General	Present	Past	No
Fever	☐	☐	☐
Chills	☐	☐	☐
Weight Loss	☐	☐	☐
Fatigue	☐	☐	☐
Night Pain	☐	☐	☐

Skin	Present	Past	No
Rash	☐	☐	☐
Itchiness	☐	☐	☐
Dryness	☐	☐	☐

Head	Present	Past	No
Headaches	☐	☐	☐
Dizziness	☐	☐	☐
TMJ pain	☐	☐	☐

Eyes	Present	Past	No
Double vision	☐	☐	☐
Blurred vision	☐	☐	☐
Eye pain	☐	☐	☐

ENT	Present	Past	No
Ringing in ears	☐	☐	☐
Hearing loss	☐	☐	☐
Loss of smell	☐	☐	☐
Nosebleeds	☐	☐	☐
Difficulty swallow	☐	☐	☐

Neck	Present	Past	No
Swollen lymph node	☐	☐	☐
Enlarged thyroid	☐	☐	☐
Rigidity	☐	☐	☐

Cardiac	Present	Past	No
Chest pain	☐	☐	☐
Difficulty breathing	☐	☐	☐
Leg swelling	☐	☐	☐
Palpitations	☐	☐	☐

Pulmonary	Present	Past	No
Short of breath	☐	☐	☐
Wheezing	☐	☐	☐
Coughing	☐	☐	☐
Cough up blood	☐	☐	☐

Gastrointestinal	Present	Past	No
Black tarry stool	☐	☐	☐
Blood in stool	☐	☐	☐
Abdominal pain	☐	☐	☐
Nausea	☐	☐	☐
Vomiting	☐	☐	☐
Constipation	☐	☐	☐
Bloating	☐	☐	☐
Bloating with meals	☐	☐	☐
Bloating after meal	☐	☐	☐
GERD	☐	☐	☐
Do you have a BM every day?		NO	YES

Genitourinary	Present	Past	No
Difficulty urination	☐	☐	☐
Blood in urine	☐	☐	☐
Frequent urination	☐	☐	☐
Discharge	☐	☐	☐
Flank pain	☐	☐	☐

Musculoskeletal	Present	Past	No
Joint pain	☐	☐	☐
Muscle pain	☐	☐	☐

Neurological	Present	Past	No
Weakness	☐	☐	☐
Numbness	☐	☐	☐
Seizures	☐	☐	☐
Numb/Tingling	☐	☐	☐

Endocrine	Present	Past	No
Thyroid disease	☐	☐	☐
Diabetes	☐	☐	☐

Other	Present	Past	No
Easy bruising	☐	☐	☐
Easy bleeding	☐	☐	☐
Anxiety	☐	☐	☐
Depression	☐	☐	☐
Hayfever	☐	☐	☐
Food allergies	☐	☐	☐
Drug allergies	☐	☐	☐