

IV. REVIEW OF SYSTEMS: (DO YOU HAVE ANY PROBLEMS IN THE FOLLOWING AREAS? (CHECK (✓) ALL THAT APPLY.)

NORMAL 1) **GENERAL HEALTH**

Fever
Weight loss
Other _____

NORMAL 2) **EYES**

Blurred vision
Double vision
Pain
Discharge
Other _____

NORMAL 3) **EARS, NOSE, MOUTH, THROAT**

Pain
Mass
Discharge
Hearing loss
Smell
Other _____

NORMAL 4) **CARDIOVASCULAR**

Chest pain
Shortness of breath
Irreg Heart Beat
Other _____

NORMAL 5) **RESPIRATORY**

Short of breath
Cough
Asthma
Other _____

NORMAL 6) **GASTROINTESTINAL**

Bowel habits/change
Diarrhea
Constipation
Stomach pain
Ulcers
Other _____

NORMAL 7) **HEMATOLOGIC/LYMPHATIC**

Anemia
Blood disease
Free bleeder
Swollen lymph nodes
Other _____

NORMAL 8) **MUSCULOSKELETAL**

Weakness
Joint pain
Decreased Range of Motion
Other _____

NORMAL 9) **INTEGUMENTARY (SKIN/BREAST)**

Masses
Tumors
Pigmented lesions
Rash
Other _____

NORMAL 10) **NEUROLOGIC**

Weakness
Tingling
Numbness
Other _____