Do you have any of the following symptoms

☐ Balance problems ☐ Difficulty walking

☐ Inability to control bowel (incontinence) ☐ Inability to control bladder (incontinence)

☐ The need for an assistive device to walk (cane, wheelchair or walker)

☐ Weakness ☐ Numbness or tingling, where _____

☐ Fever/Chills

☐ I have none of these symptoms

Review of systems

Constitution	**Eyes**	**Gastrointestinal**	**Neurological**
☐ Fever	☐ Blurred vision	☐ Heartburn	☐ Dizziness
☐ Chills	☐ Double vision	☐ Nausea	☐ Tingling
☐ Weight loss	☐ Light sensitivity	☐ Vomiting	☐ Tremor
☐ Fatigue	☐ Eye pain	☐ Diarrhea	☐ Sensory change
☐ Excessive sweating	☐ Eye discharge	☐ Abdominal pain	☐ Speech change
☐ N/A	☐ Eye redness	☐ Constipation	☐ Focal weakness
Skin	☐ N/A	☐ Blood in stool	☐ Seizures
☐ Rash	**Cardiovascular**	☐ Black stool	☐ Loss of consciousness
☐ Itching	☐ Chest pain	☐ N/A	☐ N/A
☐ N/A	☐ Rapid heart rate	**Genitourinary**	**Psychiatric**
Head/ENT	☐ Shortness of breath when laying down	☐ Painful urination	☐ Depression
☐ Headaches	☐ leg discomfort when walking	☐ Sudden need to urinate	☐ Suicidal ideation
☐ Hearing loss	☐ Leg swelling	☐ Frequency	☐ Substance abuse
☐ Ringing in ears	☐ Breathing difficulty at night while laying down	☐ Blood in urine	☐ Hallucinations
☐ Ear pain	☐ N/A	☐ Pain in upper abdomen or back	☐ Nervous/Anxious
☐ Ear discharge	**Respiratory**	☐ N/A	☐ Insomnia
☐ Nose bleeds	☐ Cough	**Endo/Allergy/Heme**	☐ Memory loss
☐ Congestion	☐ Coughing up blood	☐ Easy bruise/bleed	☐ N/A
☐ High-pitched sound when breathing	☐ Excessive phlegm/mucus	☐ Environmental allergies	
☐ Sore throat	☐ Shortness of breath	☐ Excessive thirst	
☐ N/A	☐ Wheezing	☐ N/A	
	☐ N/A		

Patient signature _____ Date: _____