Date.	Name:	
	DOB:	Age:

Medical History: Review of Systems

(Please indicate if any of the following medical conditions pertain to you)

Eyes:	Yes		No	Constitutional:	Yes		No
glaucoma	☐	√		development disability	☐	√	
cataract	☐		☐	unintended weight loss	☐		☐
macular degeneration	☐			persistant fever	☐		
inflammation	☐			chronic fatigue	☐		
vision disturbances	☐			trauma	☐		
blurry vision	☐			other	☐		
dry or watery eyes	☐						
infections	☐						
other	☐						
Cardiovascular:	Yes		No	**Musculoskeletal:**	Yes		No
heart disease	☐	√		muscle/joint pain	☐	√	
high blood pressure	☐			muscle spasms	☐		
stroke	☐		☐	muscle weakness	☐		☐
vascular disease	☐			muscle/joint swelling	☐		
other	☐			arthritis	☐		
				other	☐		
Endocrine:	Yes		No	**Gastrointestinal:**	Yes		No
diabetes	☐	√		diarrhea/contispation	☐	√	
hormonal dysfunction	☐			vomiting	☐		
cholesterol/lipid problems	☐		☐	heartburn/ ulcer	☐		☐
cancer	☐			cancer	☐		
other	☐			other	☐		
Respiratory:	Yes		No	**Allergic/Immunologic**	Yes		No
emphysema	☐	√		allergies	☐	√	
pneumonia	☐			rheumatoid arthritis	☐		
asthma	☐		☐	lupus	☐		☐
bronchitis/cough	☐			autoimmune disease	☐		
cancer	☐			other	☐		
other	☐						
Blood/Lymphatic:	Yes		No	**Integumentary (skin):**	Yes		No
anemia	☐	√		eczema/dermatitis	☐	√	
bleeding problems	☐			rosacea/acne/psoriasis	☐		
leukemia	☐		☐	cysts/warts/ulcer	☐		☐
other	☐			cancer	☐		
				other	☐		
Nervous System:	Yes		No	**Mental:**	Yes		No
seizures	☐	√		depression	☐	√	
multiple sclerosis	☐			panic/anxiety disorders	☐		
head-aches/migraines	☐		☐	mood changes	☐		☐
paralysis	☐			psychoses	☐		
numbness/ cold	☐			amnesia/sleep disorders	☐		
other	☐			other	☐		
Ears/Nose/Throat	Yes		No	**Genitourinary:**	Yes		No
runny nose/ hay fever	☐	√		genital/prostate	☐	√	
sinus congestion	☐			kidney/bladder	☐		
dry mouth/throat	☐		☐	overy/uterus/vaginal	☐		☐
cancer	☐			cancer	☐		
other	☐			other	☐		