SYSTEM REVIEW Patient Name_____

Check (✓) Appropriate Box - Please check each box				Use this space for continuation of Present Illness and/or to Describe Sympto
Yes	No	Unsure		
			Chills	
			Fever	
			Weight Change	
			Eyes:	
			Eye Pain	
			Loss of Vision	
			Double Vision	
			ENT:	
			Ear Pain	
			Deafness	
			Bleeding Nose	
			Hoarseness	
			Difficulty Swallowing	Depression
			Disturbance of Gait or Speech	
			Disturbing Feelings or Thoughts	
			Musculoskeletal:	
			Back Pain	
			Bone Infection(s)	
			Skeletal Deformities	
			Joint Pain or Swelling	
			Vericose Veins	
			Leg Ulcers	
			OB/GYN:	
			Number of Pregnancies	#_____
			Number of Vaginal Deliveries	#_____
			Non-Menstrual Bleeding	
			Excessive Menstrual Flow	
			Irregular Menstrual Flow	
			Pelvic Pain	

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