VISIONARY EYE CARE ASSOCIATES

NAME: _____ **TODAY'S DATE:** _____

DATE OF BIRTH: _____

REVIEW OF SYSTEMS

Please circle all that apply at the time of completion.

1. GENERAL

Fever Chills Loss of Appetite Fatigue None

2. RESPIRATORY

Shortness of Breath Difficulty Breathing Cough Wheezing None

3. CARDIAC

Palpitations Chest Pain Ankle Swelling None

4. NEUROLOGY

Headache Weakness Tingling Double Vision Hearing Loss None

5. GASTROINTESTINE

Abdominal Pain Diarrhea Constipation Blood in Stools None

6. SKIN

Rash Hives Sores Bruises None

7. ENDOCRINE

Heat / Cold Intolerance Weight Changes Hair Loss None

8. MUSCULOSKELETAL

Joint Pain Muscle Pain Back Pain Difficulty Walking None

9. GENITOURINARY

Pain / Burning on Urination Abnormal Bleeding None

10. PSYCHIATRIC

Anxiety Depression Hallucinations Memory Loss None