Review of Patient Systems – Patient must complete this questionnaire.

Although we specialize in allergies and asthma, we care about the "total picture" of your health – physical, mental, and emotional. Please take a few moments to fill out this form and **indicate any symptoms (new or recurring) you have experienced anytime during he last one to four weeks.** We appreciate your help in keeping up to date with how you have been feeling, as it will help us take better care of you.

Please check all that apply to you. Where there are multiple symptoms on one line (e.g. eye, nose, joints), please circle all that you have experienced.

Patient Name: _____ *Date:* _____

General:	**Yes**	**No**	**Cardiovascular:**	**Yes**	**No**
Change in mood or emotions			Unusual heartbeat		
Large weight loss/gain			Fluttering heart		
Difficulty Sleeping			Chest pain		
Loss of appetite			Swollen ankles		
Fatigue			High blood pressure		
Weakness			**Genitourinary:**		
Recurrent fever			Blood in urine		
Sweats			Pain/burning urination		
Chills			Frequent urination		
Other:			Problems with menstruation		
Eyes:			Kidney stones		
Blurred vision			Get up many times at night to urinate		
Light flashes			Current pregnancy		
Pain in eyes			Vaginal discharge, itching, burning		
Eye redness, itchiness, tearing			Testicular mass, swelling or pain		
Other:			Penile discharge		
Ear/Nose/Throat:			Sexual problems		
Hearing difficulty			Other:		
Change in hearing, ringing in ears			**Gastrointestinal:**		
Ear pain, discharge, bleeding			Indigestion/heartburn		
Vertigo			Abdominal pain		
Nose itching, sneezing, runny nose			Diarrhea		
Nose bleeding			Black tar-like stools		
Nose blockage or congestion			Nausea		
Sore throat			Vomiting		
Mouth/tooth/tongue problems			Vomiting up blood		
Persistent hoarseness			Constipation		
Other:			Difficulty swallowing		
Respiratory:			Other:		
Shortness of breath			**Skin:**		
Cough			Changing mole		
Wheezing			Rashes		
Chest tightness or pain			Bruise easily		
Coughing up blood			Itching		
Other:			Other:		

Patient Name: _____ *Date:* _____

Neck:	Yes	No	**Endocrine:**		
Swelling			Constant thirst		
Lumps			Too warm/too cold		
Other:			Jumpy/nervous		
Bones/Joints:			Other:		
Painful joints			**Psychological:**		
Swollen joints			**Do you find life:**		
Muscle pain/tenderness			Unsatisfactory		
Joint stiffness			Too demanding		
Difficulty with or loss of motion			Boring		
Bone pain or fractures			Satisfactory		
Other:			**Do you:**		
Neuromuscular:			Cry easily		
Weakness in arm/leg			Feel depressed		
Difficulty with balance			Have many fears		
Dizzy, fainting spells			Feel anxious		
History of seizure			**Have you ever:**		
Involuntary movements			Considered suicide		
Tingling			Attempted suicide		
Changes in memory					
Difficulty thinking			**Communication concerns**		
Difficulty speaking					
Numbness or loss of sensation			**Primary language**		
Difficulty with moving, weakness					
Paralysis					
Other:					

Other Problems or concerns (Please indicate below):

_____

_____

_____

_____

_____

_____

Patient Name: _____ *Date:* _____

List all current medications:

Pills/Tablets:	**Dose:**	**Frequency of use:**
Nasal Sprays:	**Dose:**	**Frequency of use:**
Lung Inhalers/Nebulized Meds:	**Dose:**	**Frequency of use:**
Eye Drops:	**Dose:**	**Frequency of use:**
Skin Creams/Ointments/Lotions:	**Dose:**	**Frequency of use:**
OTC Meds/Vitamins/ Health Food Supplements:	**Dose:**	**Frequency of use:**