

**REVIEW OF SYSTEMS:** Have you had or are you currently having any of the following?

<b>GENERAL</b>	<b>Current</b>	<b>Past</b>	<b>DIGESTIVE</b>	<b>Current</b>	<b>Past</b>
Diabetes?			Heartburn?		
Rheumatoid Arthritis?			Vomiting?		
Stroke?			Constipation?		
Recent Chemotherapy?			Diarrhea?		
Recent Radiation?			Black Stools?		
<b>HEAD. EYES. EARS</b>			Blood with Stools?		
Frequent Headaches?			<b>CARDIOVASCULAR</b>		
Dizziness?			Chest Pain?		
Ringing in Ears?			High Blood Pressure?		
Change in Hearing?			Use Oxygen at Home?		
Sore Throat?			Pacemaker?		
Trouble Swallowing?			Swelling in Ankles/Legs?		
Blurred/Double Vision?			Other?		
Poor Vision and/or Wear Glasses?			<b>MUSCLE, BONE, JOINTS</b>		
<b>RESPIRATORY</b>			Leg Pain - at rest?		
Frequent Colds?			Leg Pain - walking?		
Difficulty Breathing?			Back Pain?		
Cough • Productive?			Joint Aching/Pain?		
Asthma/Hay Fever?			Swelling of Joints?		
Emphysema?			Difficulty with Joint Motion?		
Other?			Other?		
<b>NEUROLOGICAL</b>			<b>SKIN</b>		
Change in Memory?			Rash?		
Trouble with Balance?			New Growths/Lumps?		
Change in Sensation?			Color Change in Mole or Wart?		
Where?			Skin Cancer?		
Other?			Other?		
<b>BLADDER / KIDNEY</b>					
Frequent Urination?					
Burning on Urination?					
Blood in Urine?					
Difficulty with Urination?					
Other?					

**COMMENTS:** \_\_\_\_\_

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**Date:** \_\_\_\_\_

Scott Koppel, D.P.M.

**Date:** \_\_\_\_\_