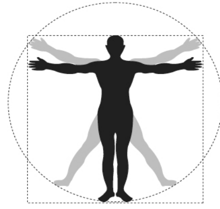

Allied Healthcare
ASSOCIATES

REVIEW OF SYSTEMS

Name:____ **Date:**______________________

In an effort to serve your medical needs as accurately as possible, please check YES if you experience any of the following on a **regular basis:**

Question	**Yes**	**No**
Neck or Back Pain?		
Headaches?		
Joint pain, stiffness or swelling?		
Balance difficulties?		
Visual or hearing disturbances?		
Unexplained weight loss?		
Difficulty swallowing?		
Nausea or vomiting?		
Diarrhea?		
Constipation?		
Chest pain?		
Heart palpitations?		
Shortness of breath?		
Cough?		
Indigestion?		
Frequent urination?		
Do you have to get up more than once nightly to urinate?		
Rashes?		
Skin wounds that will not heal?		
Easy bruising (not on aspirin or blood thinners)?		
Unusual fatigue or weakness?		
Depression or anxiety?		
Confusion or difficulties with normal thinking processes?		
Intolerance to cold or hot weather?		
Snoring?		
Unrestful sleep?		
Daytime sleepiness?		
Seizures?		
Fainting?		