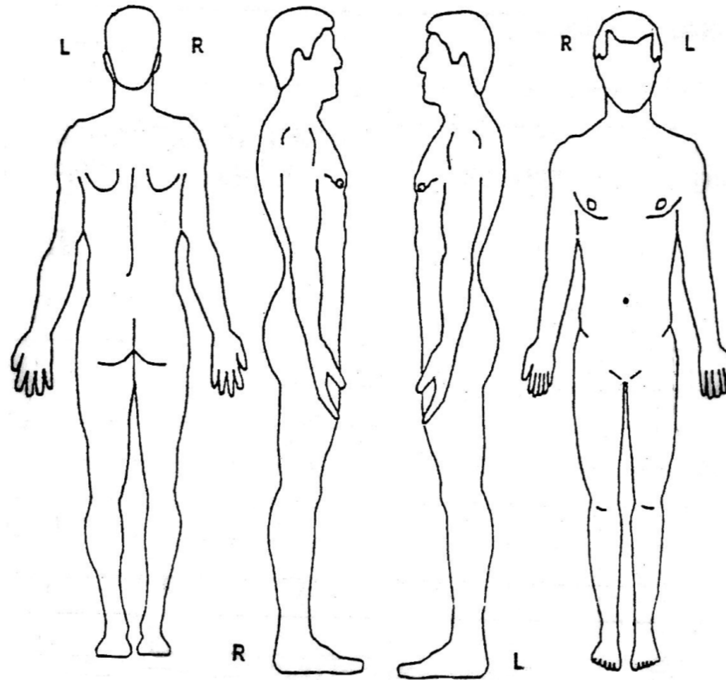
PATIENT NAME: __________________________________ DATE: ___________ PN: ___________

INSTRUCTIONS: Please mark the areas on you body where you feel your PAIN. If the pain radiates, draw an arrow from where the pain starts to where it stops. Please extend the arrows as far as the pain travels.



REVIEW OF SYSTEMS

Please write in a number: (1) PRESENTLY HAVE (2) PREVIOUSLY HAD

___Weakness
___Fatigue
___Fever
___Headaches
___Sleep Loss
___Weight Loss
___Nausea
___Wheezing
___Hearing Loss
___Bowel/Bladder Problems
___Earache
___Bloody Stool
___Sinus/Hay Fever
___Heat/Cold Intolerance
___Dizziness
___Vision Problems
___Glasses/Contact Lens
___Sexual Dysfunction
___Swallowing Difficulties
___Speech Problems/Hoarseness
___Excessive sweating

___Arthritis
___Bursitis
___Foot Trouble
___Poor Posture
___Chronic Cough
___Spinal Curvature
___Frequent Colds
___Tingling/Numbness
___Constipation
___Frequent Urination
___Inability to Control Bladder
___Memory Problems
___Fainting
___Painful Menstruation
___Joint Pain/Swelling/Stiffness
___Excessive Hunger/Thirst
___Palpitations
___Clumsiness
___Muscle Pain/Cramps
___Irritable
___Diabetes

___Heart Problems
___High Blood Pressure
___Heart Murmurs
___Poor Circulation
___Swelling of Ankles
___Chest Pain
___Depression/Nervousness
___Difficult Breathing
___Diarrhea
___Hemorrhoids
___Kidney Infection or Stones
___Loss of Appetite
___Vomiting
___Loss of Interest or Energy
___Loss of Consciousness
___Asthma
___Thyroid Problem
___Back or Neck Pain
___Stress (Emotional)
___ Seizures or Convulsions
___ Easy Bruising or Bleeding

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