

V. REVIEW OF SYSTEMS:

Please answer the following questions by checking the appropriate box. If you do not understand the questions, or if you are uncertain as to how it should be answered, leave it blank and your physician will discuss it with you. Your physician will attempt to discuss all "yes" response with you, also.

	NO	YES	Physician Notes
1. Has your weight changed more than 5 pounds in the past 6 months?			
2. Have you recently had unexplained fever, chills, or night sweats?			
3. Are you subject to unusual fatigue or lack of energy?			
4. Have headaches been a particular problem for you?			
5. Are you subject to lightheadedness, dizziness, or vertigo?			
6. Are you subject to fainting attacks?			
7. Do you think that you perspire excessively?			
8. Do you have trouble with your vision other than needing glasses?			
9. Have you recently had other trouble with your eyes?			
10. Have you ever had double vision?			
11. Is your hearing impaired?			
12. Do you have any other problem with your ears? (ringing or buzzing, draining, itching, or pain)			
13. Are you subject to stuffy nose, postnasal drip, or sinus attacks?			
14. Have you been troubled with nosebleeds?			
15. Have you recently been troubled with persistent or recurring hoarseness?			
16. Do you have frequent sore throats?			
17. Do you have any major trouble with your gums or teeth?			
18. Are you bothered with mouth or tongue problems? (canker sores, burning tongue, etc.)			
19. Are you subject to pain in the chest?			
20. Do you have spells of difficult or uncomfortable breathing?			
21. Do you become abnormally short of breath on activity or when excited?			
22. Are you subject to smothering spells which awaken you at night?			
23. Do you have to sleep propped up in bed?			
24. Are you bothered by wheezing or asthma?			
25. Do you have a persisting or chronic cough?			
26. Do you bring up any material (sputum, phlegm, mucus) from your chest?			
27. Have you ever coughed up blood?			
29. Are you subject to palpitation (thumping or racing of the heart)?			
30. Do you have a problem with abnormal fluid retention or ankle swelling?			
31. Have you been troubled with varicose veins or phlebitis?			
32. Do you regularly get pain in the legs when you walk any distance?			
33. Do you have frequent leg cramps at night ("charley-horses")?			
34. Do your fingers become painful, numb, white, or blue when they get cold?			
35. Has there been any change in your appetite recently?			
36. Have you had any trouble swallowing food or liquids?			
37. Are you troubled with heartburn, indigestion, gas, or bloating?			
38. Are you subject to spells of nausea or vomiting?			
39. Do you have a problem with pains or cramps in the abdomen?			
40. Have your bowel habits changed in the past six months?			
41. Do you have trouble with constipation or diarrhea?			
43. Do you use laxatives or enemas regularly?			
44. Do you have rectal pain or pain with bowel movements?			
45. Have you ever had black or tarry stools, or bright red blood in your stools?			
46. Do you have pale or clay colored stools?			
47. Do you pass mucus in your stools?			