Review of Systems

Do you currently, or have you ever had *any* problems in the following areas: (If YES, please explain and list medications)

System	Yes	No	Explain	Medication
VASCULAR				
Heart Pain				
High Blood Pressure				
Vascular Disease				
EAR,NOSE,MOUTH THROAT				
Post-Nasal Drip				
Chronic Cough				
Dry Throat / Mouth				
Hay Fever				
Sinus Congestion				
Runny Nose				
Other				
RESPIRATORY				
Asthma				
Chronic Bronchitis				
Emphysema				
GASTROINTESTINAL				
Diarrhea				
Constipation				
GENITOURINARY (genitals / kidney / bladder)				
BONES / JOINTS / MUSCLES				
Rheumatoid Arthritis				
Muscle Pain				
INTEGMENTARY(skin)				
NEUROLOGIC				
Headaches				
Migraines				
Seizures				
PSYCHIATRIC				
ENDOCRINE(thyroid / other glands)				
LYMPHATIC/HEMATOLOGIC				
Anemia				
Bleeding Problems				
ALLERGIES				
Seasonal				
Year Round				
Other				
EYES				
Glaucoma				
Cataracts				
Macular Degeneration				
Eye Injury				
Retinal Disease				
Other Eye Disease				
Blindness				
Crosses Eyes				
Amblyopia				
Diabetes				
Dry Eye				
Flashes/Floaters in vision				
Other				

Do you use a computer?_____ How many hrs. a day?_____