

REVIEW OF SYSTEMS

Please use the scale below (0 to 4) to rate each of the symptoms on this page according to your health status over the past 30 days: 0 = Never have this symptom

- 1 = Occasionally have this symptom, effect not severe
- 2 = Occasionally have this symptom, effect is severe
- 3 = Frequently have this symptom, effect not severe
- 4 = Frequently have this symptom, effect is severe

Head: <input type="checkbox"/> Headaches <input type="checkbox"/> Faintness <input type="checkbox"/> Dizziness <input type="checkbox"/> Insomnia	Energy/Activity: <input type="checkbox"/> Fatigue/Sluggishness <input type="checkbox"/> Apathy/Lethargy <input type="checkbox"/> Hyperactivity <input type="checkbox"/> Restlessness	Lungs: <input type="checkbox"/> Chest Congestion <input type="checkbox"/> Asthma, Bronchitis <input type="checkbox"/> Shortness Of Breath <input type="checkbox"/> Difficulty Breathing
Eyes: <input type="checkbox"/> Watery or Itchy Eyes <input type="checkbox"/> Swollen, Red or Sticky Eyelids <input type="checkbox"/> Bags or Dark Circles Under Eyes <input type="checkbox"/> Blurred or Tunnel Vision (not including near or far sightedness)	Weight: <input type="checkbox"/> Binge Eating/Drinking <input type="checkbox"/> Craving Certain Foods <input type="checkbox"/> Excessive Weight <input type="checkbox"/> Compulsive Eating <input type="checkbox"/> Water Retention <input type="checkbox"/> Underweight	Heart: <input type="checkbox"/> Irregular or Skipped Heartbeat <input type="checkbox"/> Rapid or Pounding Heartbeat <input type="checkbox"/> Chest Pain
Ears: <input type="checkbox"/> Itchy Ears <input type="checkbox"/> Earaches, Ear Infections <input type="checkbox"/> Drainage From Ear <input type="checkbox"/> Ringing In Ears, Hearing Loss	Emotions: <input type="checkbox"/> Mood Swings <input type="checkbox"/> Anxiety/Fear/Nervousness <input type="checkbox"/> Anger/Irritability/Aggressiveness <input type="checkbox"/> Depression	Digestive Tract: <input type="checkbox"/> Nausea, Vomiting <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Bloating Feeling <input type="checkbox"/> Belching, Passing Gas <input type="checkbox"/> Heartburn <input type="checkbox"/> Intestinal/Stomach Pain
Nose: <input type="checkbox"/> Stuffy Nose <input type="checkbox"/> Sinus Problems <input type="checkbox"/> Hay Fever <input type="checkbox"/> Sneezing Attacks <input type="checkbox"/> Excessive Mucus Formation	Mind: <input type="checkbox"/> Poor Memory <input type="checkbox"/> Confusion, Poor Comprehension <input type="checkbox"/> Poor Concentration <input type="checkbox"/> Poor Physical Condition <input type="checkbox"/> Difficulty Making Decisions <input type="checkbox"/> Stuttering or Stammering <input type="checkbox"/> Slurred speech	Other: <input type="checkbox"/> Frequent Illness <input type="checkbox"/> Frequent or Urgent Urination <input type="checkbox"/> Genital Itch or Discharge
Mouth & Throat: <input type="checkbox"/> Chronic Coughing <input type="checkbox"/> Frequent Need to Clear Throat <input type="checkbox"/> Sore Throat, Hoarseness <input type="checkbox"/> Swollen or Discolored Tongue <input type="checkbox"/> Canker Sores	Joints/Muscles: <input type="checkbox"/> Pain or Aches in Joints <input type="checkbox"/> Arthritis <input type="checkbox"/> Stiffness or Limited Movement <input type="checkbox"/> Pain or Aches in Muscles <input type="checkbox"/> Weakness or Fatigued Muscles	Grand Total: