

REVIEW OF SYSTEMS

DO YOU HAVE ANY OF THE FOLLOWING:

If the answer is yes, please mark an "X" next to the condition.

- _____ 1. Do you have excessive sweating?
- _____ 2. Asthma
- _____ 3. Hay fever/seasonal allergies
- _____ 4. History of TB or exposure to TB
- _____ 5. History of heart attacks
- _____ 6. High blood pressure
- _____ 7. Night sweats
- _____ 8. Depression
- _____ 9. Seizures
- _____ 10. Hallucinations
- _____ 11. Cancer
If yes, what type? _____
- _____ 12. Have you ever had psychiatric help?
- _____ 13. Have you ever been unconscious?
- _____ 14. Abdominal pain
- _____ 15. History of hepatitis
- _____ 16. Extended muscle pain
- _____ 17. Arthritis
- _____ 18. Painful urination
- _____ 19. Diabetes
- _____ 20. Thyroid disease
- _____ 21. Sensitivity to cold
- _____ 22. History of eczema
- _____ 23. History of psoriasis
- _____ 24. History of blood transfusions
- _____ 25. History of intravenous drug abuse
- _____ 26. Have you ever been tested for HIV?
If yes, what were your results? _____
- _____ 27. Any family history of skin cancer or other cancer?
If yes, please describe _____
- _____ 28. Any family history of melanoma?

FOR WOMEN ONLY:

- _____ 1. Do you have abnormal periods?
- _____ 2. Do you have excessive body hair?
- _____ 3. Could you be pregnant?

IF NONE APPLY PLEASE INITIAL HERE _____