

**Patient Review of System**

**Please mark any issue(s) that you are currently experiencing:**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Eye** | | |  | **Genitourinary** | | |
|  | **Yes** | **No** |  |  | **Yes** | **No** |
| **Glaucoma** |  |  |  | **Kidney Disease** |  |  |
| **Cataract** |  |  |  | **Pregnant** |  |  |
| **Macular Degeneration** |  |  |  | **Nursing** |  |  |
| **Loss of Vision** |  |  |  | **Herpes** |  |  |
| **Blurred Vision** |  |  |  | **Chlamydia** |  |  |
| **Itching** |  |  |  |  |  |  |
| **Redness** |  |  |  | **Musculoskeletal** | | |
| **Tearing** |  |  |  |  | **Yes** | **No** |
| **Pain** |  |  |  | **Arthritis** |  |  |
|  |  |  |  | **Osteoarthritis** |  |  |
| **Constitution** | | |  | **Fibromyalgia** |  |  |
|  | **Yes** | **No** |  | **Muscular Dystrophy** |  |  |
| **Developmental Disabilites** |  |  |  | **Ankylosing Spndylitis** |  |  |
| **Cancer** |  |  |  |  |  |  |
|  |  |  |  | **Integumentary** | | |
| **Neurological** | | |  |  | **Yes** | **No** |
|  | **Yes** | **No** |  | **Eczema** |  |  |
| **Multiple Sclerosis** |  |  |  | **Rosacea** |  |  |
| **Epilepsy** |  |  |  | **Psoriasis** |  |  |
| **Tumor** |  |  |  | **Cold Sores** |  |  |
| **Stroke/CVA** |  |  |  | **Shingles** |  |  |
| **Migraine** |  |  |  |  |  |  |
| **Autism Spectrum Disorder** |  |  |  | **Endocrine** | | |
|  |  |  |  |  | **Yes** | **No** |
| **Psychological** | | |  | **Type 2 Diabetes** |  |  |
|  | **Yes** | **No** |  | **Type 1 Diabetes** |  |  |
| **Depression** |  |  |  | **Thyroid Dysfunction** |  |  |
| **Attention Deficit** |  |  |  | **Hormonal Dysfunction** |  |  |
| **Anxiety Disorder** |  |  |  |  |  |  |
| **Bipolar Disorder** |  |  |  | **Hematological/Lymphatic** | | |
|  |  |  |  |  | **Yes** | **No** |
| **Cardiovascular** | | |  | **Anemia** |  |  |
|  | **Yes** | **No** |  | **High Cholesterol** |  |  |
| **High Blood Pressure** |  |  |  |  |  |  |
| **Stroke/CVA** |  |  |  | **Allergic/Immune** | | |
| **Heart Disease** |  |  |  |  | **Yes** | **No** |
| **Vascular Disease** |  |  |  | **Drug Allergies** |  |  |
|  |  |  |  | **Environmetal Allergies** |  |  |
| **Respiratory** | | |  | **Rheumatoid Arthritis** |  |  |
|  | **Yes** | **No** |  | **Lupus** |  |  |
| **Cigarette Smoker** |  |  |  | **Sjogren's Syndrome** |  |  |
| **Asthma** |  |  |  |  |  |  |