



# Fullerton Neurology and Headache Center

100 Laguna Road, Suite 208, Fullerton, CA 92835  
Ph: 714-738-0800 · Fax: 714-738-3758 · fullertonneuro@fullertonneuro.net

## TO OUR PATIENTS:

Please complete the following 14-point Review of Systems. **Please mark if you currently have any of the following symptoms or conditions.** Explain in more detail, if needed, on the back of this form or by adding an attachment. By reviewing your total health status, we can better treat your neurologic problems. Thank you.

PATIENT'S NAME: _____, _____	<i>Physician Use Only</i>
<b>CONSTITUTIONAL</b> <input type="checkbox"/> fevers/chills <input type="checkbox"/> weight loss <input type="checkbox"/> weight gain <input type="checkbox"/> night sweats <input type="checkbox"/> fatigue <input type="checkbox"/> None of the above.	
<b>EYES</b> <input type="checkbox"/> blurry vision <input type="checkbox"/> loss of vision <input type="checkbox"/> double vision <input type="checkbox"/> cataracts <input type="checkbox"/> glaucoma <input type="checkbox"/> None of the above.	
<b>EARS, NOSE, THROAT</b> <input type="checkbox"/> ear pain <input type="checkbox"/> ringing in ears <input type="checkbox"/> vertigo <input type="checkbox"/> runny nose <input type="checkbox"/> congestion <input type="checkbox"/> sinus disease <input type="checkbox"/> flu <input type="checkbox"/> throat pain <input type="checkbox"/> difficulty swallowing <input type="checkbox"/> None of the above.	
<b>CARDIOVASCULAR</b> <input type="checkbox"/> chest pain/angina <input type="checkbox"/> palpitations <input type="checkbox"/> irregular heartbeat <input type="checkbox"/> high cholesterol <input type="checkbox"/> peripheral artery disease <input type="checkbox"/> carotid artery disease <input type="checkbox"/> coronary artery bypass <input type="checkbox"/> high blood pressure <input type="checkbox"/> None of the above.	
<b>RESPIRATORY</b> <input type="checkbox"/> cough <input type="checkbox"/> asthma <input type="checkbox"/> COPD <input type="checkbox"/> bronchitis <input type="checkbox"/> pneumonia <input type="checkbox"/> shortness of breath <input type="checkbox"/> shortness of breath upon lying flat <input type="checkbox"/> None of the above.	
<b>GASTROINTESTINAL</b> <input type="checkbox"/> Gastroesophageal reflux <input type="checkbox"/> peptic ulcer <input type="checkbox"/> diarrhea <input type="checkbox"/> bloody stool <input type="checkbox"/> black tarry stool <input type="checkbox"/> nausea <input type="checkbox"/> vomiting <input type="checkbox"/> bowel incontinence <input type="checkbox"/> None of the above.	
<b>GENITOURINARY</b> <input type="checkbox"/> urinary urgency <input type="checkbox"/> urinary frequency <input type="checkbox"/> painful urination <input type="checkbox"/> bloody urine <input type="checkbox"/> bladder incontinence <input type="checkbox"/> irregular/no mensus <input type="checkbox"/> vaginal bleeding <input type="checkbox"/> breast discharge <input type="checkbox"/> sexually transmitted disease: <input type="checkbox"/> None of the above.	
<b>MUSCULOSKELETAL</b> <input type="checkbox"/> muscle pain <input type="checkbox"/> neck pain <input type="checkbox"/> back pain <input type="checkbox"/> joint pain <input type="checkbox"/> arthritis <input type="checkbox"/> osteoporosis <input type="checkbox"/> None of the above.	
<b>NEUROLOGIC</b> <input type="checkbox"/> headaches <input type="checkbox"/> dizziness <input type="checkbox"/> numbness/tingling <input type="checkbox"/> muscle weakness <input type="checkbox"/> abnormal gait <input type="checkbox"/> seizures <input type="checkbox"/> loss of consciousness <input type="checkbox"/> memory loss <input type="checkbox"/> difficulty concentrating <input type="checkbox"/> tremor <input type="checkbox"/> difficulty performing previously learned / known tasks <input type="checkbox"/> None of the above.	

<b>14-POINT REVIEW OF SYSTEMS (continued)</b>	<i>Physician Use Only</i>
<p><b>PSYCHIATRIC</b>  <input type="checkbox"/> depression                      <input type="checkbox"/> anxiety/panic attacks  <input type="checkbox"/> delusions/hallucinations      <input type="checkbox"/> bipolar disorder  <input type="checkbox"/> None of the above.</p>	
<p><b>DERMATOLOGIC</b>  <input type="checkbox"/> rash                      <input type="checkbox"/> hives                      <input type="checkbox"/> psoriasis  <input type="checkbox"/> skin infection      <input type="checkbox"/> other:  <input type="checkbox"/> None of the above.</p>	
<p><b>ENDOCRINE</b>  <input type="checkbox"/> diabetes                      <input type="checkbox"/> thyroid disorder                      specify type:  <input type="checkbox"/> None of the above.</p>	
<p><b>ALLERGY / IMMUNOLOGY</b>  <input type="checkbox"/> nasal allergies                      <input type="checkbox"/> food allergies  <input type="checkbox"/> immunodeficiency (example: HIV)  <input type="checkbox"/> None of the above.</p>	
<p><b>HEMATOLOGIC / LYMPHATIC</b>  <input type="checkbox"/> anemia                      <input type="checkbox"/> cancer  <input type="checkbox"/> bleeds easily      <input type="checkbox"/> lymph node tenderness/enlargement  <input type="checkbox"/> blood disorder:  <input type="checkbox"/> None of the above.</p>	
<p><b>COMPLETED BY:</b></p>   <p><b>DATE:</b></p>	<p><b>REVIEWED BY:</b>  <input type="checkbox"/> Jack H Florin MD  <input type="checkbox"/> Allison Kennedy, MPAP, PA-C</p> <p><b>INITIALS:</b>                      <b>DATE:</b></p>