



### Systems Review

#### **Nervous System**

<input type="checkbox"/> Paralysis	<input type="checkbox"/> Nervousness	<input type="checkbox"/> Insomnia	<input type="checkbox"/> Tremors
<input type="checkbox"/> Convulsions	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Fainting	<input type="checkbox"/> Tingling
<input type="checkbox"/> Confusion	<input type="checkbox"/> Irritability	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Numbness
<input type="checkbox"/> Forgetfulness	<input type="checkbox"/> Hiccups	<input type="checkbox"/> Depression	<input type="checkbox"/> Hot/Cold Spots

#### **Eye, Ear, Nose & Throat**

<input type="checkbox"/> Vision Problems	<input type="checkbox"/> Hearing Loss	<input type="checkbox"/> Nose Pain	<input type="checkbox"/> Dental Problems
<input type="checkbox"/> Zig Zag Flashes	<input type="checkbox"/> Ear Discharge	<input type="checkbox"/> Nose Bleeding	<input type="checkbox"/> Difficulty Speaking
<input type="checkbox"/> Visual Disturbance	<input type="checkbox"/> Chronic Earache	<input type="checkbox"/> Sinus Trouble	<input type="checkbox"/> Sore Mouth
<input type="checkbox"/> Eye Inflammation	<input type="checkbox"/> Ear Noises	<input type="checkbox"/> Hay Fever	<input type="checkbox"/> Sore Throat
<input type="checkbox"/> Light Sensitivity	<input type="checkbox"/> Head Colds	<input type="checkbox"/> Difficulty Breathing	<input type="checkbox"/> Canker Sores
<input type="checkbox"/> Eye Strain	<input type="checkbox"/> Nose Discharge		<input type="checkbox"/> Hoarseness

#### **Respiratory**

<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Asthma	<input type="checkbox"/> Allergies	<input type="checkbox"/> Bronchitis
<input type="checkbox"/> Difficulty Breathing	<input type="checkbox"/> Coughing Phlegm	<input type="checkbox"/> Chronic Cough	<input type="checkbox"/> Chest Colds

#### **Cardio-Vascular**

<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Stroke	<input type="checkbox"/> Pain Over Heart	<input type="checkbox"/> Varicose Veins
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Rapid Heart Rate	<input type="checkbox"/> Atherosclerosis	<input type="checkbox"/> Poor Circulation
<input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> Slow Heart Rate	<input type="checkbox"/> Ankle Swelling	

#### **Skin**

<input type="checkbox"/> Shingles	<input type="checkbox"/> Hives	<input type="checkbox"/> Boils	<input type="checkbox"/> Acne
<input type="checkbox"/> Skin Disorders	<input type="checkbox"/> Itching	<input type="checkbox"/> Bruise Easily	<input type="checkbox"/> Dryness

#### **Gastro-Intestinal**

<input type="checkbox"/> Ulcers	<input type="checkbox"/> Acid Stomach	<input type="checkbox"/> Belching Gas	<input type="checkbox"/> Difficulty Chewing
<input type="checkbox"/> Gastritis	<input type="checkbox"/> Vomiting	<input type="checkbox"/> Vomit Blood	

#### **Genito-Urinary**

<input type="checkbox"/> Urine Disorder - excessive, painful, discolored	<input type="checkbox"/> Bladder Infections	<input type="checkbox"/> Kidney Infections	<input type="checkbox"/> Prostatitis
	<input type="checkbox"/> Yeast Infection	<input type="checkbox"/> Bed Wetting	<input type="checkbox"/> Impotency
	<input type="checkbox"/> Incontinence	<input type="checkbox"/> Kidney Disorder	

#### **Female**

<input type="checkbox"/> Painful Periods excessive, irregular	<input type="checkbox"/> Hot Flashes	<input type="checkbox"/> Breast Lumps	<input type="checkbox"/> Pregnant? Y or N
	<input type="checkbox"/> Menopause		

#### **General**

<input type="checkbox"/> Cancer	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Fevers	<input type="checkbox"/> Weight Loss/Gain
<input type="checkbox"/> Thyroid Disorder	<input type="checkbox"/> Chronic Fatigue	<input type="checkbox"/> Chills	<input type="checkbox"/> Chronic Pain