



# NEW YORK HEADACHE CENTER

## Review of Systems

Name..... Date.....

Since the LAST VISIT, are you:  BETTER  WORSE  THE SAME

Do you have any NEW problems/new medications?  Yes  No.

Since the LAST VISIT have you had any of the following problems:

Y N

- Change in marital status.....
- Change in job/school.....
- Emotional trauma.....
- Change in smoking/drinking/diet
  
- Hospitalization/surgery.....
- Fatigue.....
- Weight loss/gain:.....
- Allergic reaction.....
- New illness diagnosed.....
- Fever/chills.....
  
- High blood pressure.....
- Palpitations.....
- Breathing difficulty.....
- Chest pain.....
- Swelling.....
  
- Chronic cough.....
- Wheezing.....
  
- Bleeding/bruising.....
  
- Diarrhea.....
- Constipation.....
- Nausea/vomiting.....
  
- Joint pain/swelling/redness.....
- Muscle aches.....
  
- Sexual dysfunction.....
- Breast lumps/discharge.....
- Symptoms of menopause.....
- Irregular periods.....
- PMS.....
- Bladder problems.....

Y N

- Cold extremities.....
- Leg/foot cramps.....
  
- Depression.....
- Anxiety/panic attacks.....
  
- Change in skin/hair.....
- Excessive urination or thirst.....
  
- Insomnia.....
- Leg restlessness.....
- Daytime sleepiness.....
- Snoring.....
- Sleep apnea.....
- Teeth grinding/clenching.....
  
- Seizures/shaking.....
- Headaches.....
- Back pain.....
- Neck pain.....
- Decline in memory.....
- Weakness.....
- Numbness.....
- Hearing/vision problems.....
- Loss of consciousness.....
- Dizziness.....
  
- Dental problems.....
- Sinus problems.....
- Hoarseness.....
  
- Any other problems not listed.....

Reviewed with patient on:

MD signature:

Manhattan:  
30 East 76th Street,  
New York, NY 10021  
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Brooklyn:  
132 Atlantic Avenue,  
Brooklyn, NY 11201  
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