Print in Color or Grayscale Only
Using Adobe Acrobat Reader 8.0 or later

Review of Systems

Please answer every question

Marking Instructions

Please use a # 2 pencil
Fill in the complete oval as shown...

PLEASE PRINT PATIENT'S LAST NAME

PLEASE PRINT PATIENT'S FIRST NAME

PATIENT'S DATE OF BIRTH

Month Day Year

Please mark only the symptoms you CURRENTLY are experiencing.

Mark all that apply ---- if no symptoms, please mark "NONE"

General			
fatigue ○	weight loss ○	fever ○	
night sweats ○	weight gain ○	persistent infections ○	NONE ○
Eyes			
		visual disturbances ○	NONE ○
Ear, Nose, and Throat			
	seasonal allergies ○	sinus pain ○	
hearing loss ○	recurrent nose bleeds ○	oral ulcers ○	NONE ○
Cardiovascular			
lightheadedness ○	palpitations ○	chest pain ○	
difficulty breathing on exertions ○	swelling hands/feet ○	shortness of breath ○	NONE ○
Respiratory			
snoring ○	difficulty breathing ○	chronic cough ○	
excessive daytime sleepiness ○	wheezing ○	coughing blood ○	NONE ○
Gastrointestinal			
	constipation ○	bloody stool ○	
nausea ○	chronic diarrhea ○	indigestion ○	
change in bowel habits ○	abdominal pain ○	vomiting ○	NONE ○
Female Genitourinary (Women Only)			
urine leakage ○	urinary frequency ○	painful urination ○	
excessive urination at night ○	urinary urgency ○	blood in urine ○	NONE ○
Male Genitourinary (Men Only)			
		urine leakage ○	
change in urinary stream ○	urinary frequency ○	painful urination ○	
excessive urination at night ○	urinary urgency ○	blood in urine ○	NONE ○
Musculoskeletal			
joint pain ○	muscle pain ○	muscle weakness ○	NONE ○
Skin			
	rash ○	new sore / lesion ○	
dry skin ○	hives ○	skin ulcer ○	NONE ○
Neurologic			
		tremors ○	
fainting ○	numbness ○	seizures ○	
decreased memory ○	trouble walking ○	headaches ○	NONE ○
Psychiatric			
	depression ○	anxiety ○	
change in sleep pattern ○	suicidal thoughts ○	fearful ○	NONE ○
Endocrine			
	hot flashes ○	cold intolerance ○	
hair changes ○	excessive sweating ○	heat intolerance ○	NONE ○
Heme/Lymphatic			
	easy bruising ○	excessive bleeding ○	NONE ○