Print in Color or Grayscale Only

Using Adobe Acrobat Reader 8.0 or later

Review of Systems

Please answer every question

	PLE	ASE	PRII	NT PA	ATIE	NT'S	LAS	T N	AME										
Marking Instructions																			
Please use a # 2 pencil	PLE	ASE	PRII	NT PA	ATIE	NT'S	FIR	ST N	IAMI	E		PAT	IENT	'S DA	TE O	F BIF	RTH		
Fill in the complete oval as shown																			
												Mon	th	С	ay		,	/ear	

Please mark only the symptoms you **CURRENTLY** are experiencing.

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

Female Genitourinary (Women Only) Female Genitourinary (Women Only) Lear, Nose, and glate seepings where seeping in the seep
Ear, Nose, and Throat Seasonal allergies Sinus pain 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 coughing blood NONE Gastrointestinal constipation bloody stool indigestion nausea chronic diarrhea indigestion change in bowel habits abdominal pain vomiting NONE Female Genitourinary (Women Only) urine leakage urinary trequency painful urination none none change in urinary stream urinary frequency painful urination none none change in urinary stream urinary frequency painful urination none
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Musculoskeletal joint pain muscle pain muscle weakness NONE
joint pain muscle pain muscle weakness NONE
Skin
rash onew sore / lesion onew sore /
dry skin Ohives skin ulcer NONE
Neurologic
tremors
fainting numbness seizures
decreased memory trouble walking headaches NONE
Psychiatric
depression anxiety 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