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

Review of Systems

Please answer every question

PLEASE PRINT PATIENT'S LAST NAME

PLEASE PRINT PATIENT'S FIRST NAME

PATIENT'S DATE OF BIRTH

Month Day Year

Marking Instructions

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

Please mark only the symptoms you CURRENTLY are experiencing.

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

General
fever ○ | weight loss ○ | persistent infections ○
fatigue ○ | weight gain ○ | NONE ○

Eyes
visual disturbances ○ | glasses/contacts ○ | NONE ○

Ear, Nose, and Throat
hearing loss ○ | sinus pain ○
seasonal allergies ○ | oral ulcers ○ | NONE ○

Cardiovascular
chest pain ○ | palpitations ○ | difficulty breathing on exertions ○
shortness of breath ○ | swelling hands/feet ○ | NONE ○

Respiratory
difficulty breathing ○ | chronic cough ○
wheezing ○ | coughing blood ○ | NONE ○

Breast
mass/lump ○ | breast pain ○ | nipple discharge ○ | NONE ○

Gastrointestinal
nausea ○ | constipation ○ | bloody stool ○ | indigestion ○
vomiting ○ | chronic diarrhea ○ | hemorrhoids ○
change in bowel habits ○ | abdominal pain ○ | excessive gas ○ | NONE ○

Female Genitourinary (Women Only)
vaginal dryness ○ | painful urination ○ | pelvic pain ○
urinary frequency ○ | vaginal discharge ○ | painful menstruation ○ | blood in urine ○
urinary urgency ○ | vaginal itch or burning ○ | menstrual irregularities ○
excessive urination at night ○ | painful intercourse ○ | urine leakage ○ | NONE ○

Male Genitourinary (Men Only)
urinary frequency ○ | testicular mass ○ | urine leakage ○
painful urination ○ | urinary urgency ○ | testicular pain ○
change in urinary stream ○ | impotence ○ | penile lesions ○
excessive urination at night ○ | urethral discharge ○ | blood in urine ○ | NONE ○

Musculoskeletal
joint pain ○ | muscle pain ○ | muscle weakness ○ | NONE ○

Skin
dry skin ○ | rash ○ | new sore/lesion ○
change in wart or mole ○ | hives ○ | skin ulcer ○ | NONE ○

Neurologic
fainting ○ | numbness ○ | seizures ○
decreased memory ○ | trouble walking ○ | headaches ○ | NONE ○

Psychiatric
anxiety ○ | frequent crying ○ | fearful ○
change in sleep pattern ○ | depression ○ | NONE ○

Endocrine
hair changes ○ | heat intolerance ○ | cold intolerance ○
hot flashes ○ | NONE ○

Heme/Lymphatic
easy bruising ○ | excessive bleeding ○ | gland problems ○ | NONE ○