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 are CURRENTLY experiencing.

Mark all that apply. If no symptoms, please mark "NONE."

GASTROINTESTINAL

- intestinal infection
- difficulty swallowing
- nausea
- vomiting
- get full quickly at meals
- vomiting blood
- heartburn / reflux
- belching
- food / milk intolerance
- abdominal swelling / bloating
- jaundice (yellow skin)
- gas / flatulence
- pain with bowel movements
- diarrhea
- laxative use
- constipation
- stool incontinence
- black / tarry stools
- blood in stool
- change in bowel habits
- abdominal pain

NONE

GENERAL

- headaches
- tiredness
- night sweats
- unintentional weight loss (over 10 lbs)
- fever
- lack of appetite

NONE

HEENT

- difficult swallowing
- seasonal allergies
- hoarseness
- decreased hearing
- wear contacts / glasses
- sore throat

NONE

CARDIOVASCULAR

- chest pain
- irregular heartbeat
- fainting / blacking out
- swelling of the legs
- swelling of hands and feet
- palpitations
- leg cramps

NONE

RESPIRATORY

- shortness of breath
- chronic cough
- difficulty breathing
- wheezing

NONE

NEUROLOGICAL

- speech difficulty
- loss of consciousness
- seizure
- weakness in extremities
- fainting
- dizziness

NONE

ENDOCRINE

- cold intolerance
- heat intolerance
- excessive urination
- excessive thirst

NONE

MUSCULOSKELETAL

- physical disability
- joint pain
- neck pain
- back pain

NONE

SKIN

- itching
- rash

NONE

GENITOURINARY

- painful urination
- blood in urine
- change in urination stream
- frequent urination
- pelvic pain

NONE

PSYCHIATRIC

- stress related symptoms
- suicidal thoughts
- depression
- anxiety

NONE

BLOOD

- easy bleeding
- easy bruising

NONE