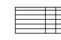
Print in Color or Grayscale Only
Using Adobe Acrobat Reader 8.0 or later

Review of Systems

Please answer every question

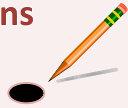


STAFF: Handwritten responses must be entered **MANUALLY**.

PLEASE PRINT PATIENT'S LAST NAME

Marking Instructions

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



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."

GENERAL
- fever ◯
- chills ◯
- night sweats ◯
- feeling poorly (malaise) ◯
- feeling tired ◯
- recent weight gain ◯
- recent weight loss ◯
- NONE ◯

CARDIOVASCULAR
- heart rate is slow ◯
- heart rate is fast ◯
- cold hands or feet ◯
- chest pain ◯
- palpitations ◯
- limb swelling ◯
- leg cramping ◯
- generalized warmth of skin ◯
- NONE ◯

SKIN
- skin rash ◯
- skin lesions ◯
- skin wound ◯
- redness ◯
- itching ◯
- change in a mole ◯
- psoriasis ◯
- change in skin color ◯
- problems with healing wound ◯
- NONE ◯

EARS / NOSE / THROAT
- wears hearing aid ◯
- loss of hearing ◯
- difficulty swallowing ◯
- hoarseness ◯
- nose bleeds ◯
- sinus pain ◯
- NONE ◯

ENDOCRINE
- excessive thirst ◯
- heat / cold intolerance ◯
- hot flashes ◯
- NONE ◯

EYES
- visual disturbances ◯
- vision prescription ◯
- NONE ◯

GASTROINTESTINAL
- abdominal pain ◯
- constipation ◯
- difficulty swallowing ◯
- nausea ◯
- diarrhea ◯
- heartburn ◯
- vomiting ◯
- bloody stools ◯
- NONE ◯

GENITOURINARY
- painful urination ◯
- incontinence ◯
- pelvic pain ◯
- blood in urine ◯
- kidney disease ◯
- NONE ◯

HEMATOLOGIC / LYMPHATIC
- easy bruising ◯
- easy bleeding ◯
- NONE ◯

MUSCULOSKELETAL
- joint pain ◯
- muscle pain ◯
- decreased range of motion ◯
- joint swelling ◯
- limb pain ◯
- shooting pain ◯
- joint stiffness / locking ◯
- back pain ◯
- neck pain ◯
- NONE ◯

NEUROLOGICAL
- headache ◯
- confusion ◯
- fainting ◯
- numbness ◯
- tingling ◯
- dizziness ◯
- limb weakness ◯
- difficulty walking ◯
- NONE ◯

PSYCHIATRIC
- suicidal ◯
- sleep disturbances ◯
- alcohol abuse ◯
- anxiety ◯
- depression ◯
- stress ◯
- emotional problems ◯
- drug abuse ◯
- claustrophobia ◯
- NONE ◯

RESPIRATORY
- shortness of breath ◯
- wheezing ◯
- cough ◯
- shortness of breath on exertion ◯
- NONE ◯

OTHER SYMPTOMS

please list: ______________________________

(U.S. Patent No. 7,487,102) (U.S. Patent No. 7,941,328)

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