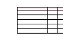
Print in Color or Grayscale Only
Using Adobe Acrobat Reader 8.0 or later

Review of Systems

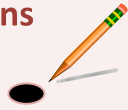
Please answer every question.



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

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 all symptoms you are CURRENTLY experiencing.

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

Category	Symptoms	Symptoms	
GENERAL	trouble sleeping ◯ recent weight loss ◯	fatigue ◯ loss of appetite ◯	NONE ◯
CARDIOVASCULAR		chest pain ◯ palpitations ◯	NONE ◯

please fold on dotted line

Category	Symptoms	Symptoms	
SKIN	frequent rashes ◯ skin ulcers ◯	lumps ◯ non-healing wound ◯	NONE ◯
EAR / NOSE / THROAT	hearing loss ◯	hoarseness ◯ trouble swallowing ◯	NONE ◯
ENDOCRINE		cold intolerance ◯ heat intolerance ◯	NONE ◯
EYES	vision loss ◯	blurred vision ◯ double vision ◯	NONE ◯
GASTROINTESTINAL	heartburn ◯ ulcers ◯	nausea ◯ vomiting ◯ blood in stool ◯	NONE ◯
GENITOURINARY		painful urination ◯ blood in urine ◯	NONE ◯
HEMATOLOGIC / LYMPHATIC		easy bleeding ◯ easy bruising ◯	NONE ◯

please fold on dotted line

Category	Symptoms	Symptoms	
NEUROLOGICAL	headaches ◯ dizziness ◯	seizures ◯ numbness ◯	NONE ◯
PSYCHIATRIC	substance abuse ◯	feeling anxious ◯ feeling depressed ◯	NONE ◯
RESPIRATORY		chronic cough ◯ shortness of breath ◯	NONE ◯

OTHER SYMPTOMS Please list: ____________________

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

SAMPLE

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