Do not write, stamp, punch holes or affix a sticker in this area.

Review of Systems

Please answer every question

To reproduce, follow the printing instructions. Do not fold this form.

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

First Visit: Mark all symptoms that pertain to you.

Repeat Visit: Mark only the symptoms that you have experienced since your last visit.

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

NO CHANGES SINCE LAST VISIT ○

GENERAL	weight loss ○ weight gain ○	fevers ○ night sweats ○	NONE ○
EYES	cataracts ○	blurring ○	NONE ○
EARS / NOSE / THROAT	difficulty swallowing ○ ringing in the ears ○	hoarseness ○ nosebleeds ○	NONE ○
CARDIOVASCULAR	fainting ○ leg pain with exertion ○ chest pain or discomfort ○ swelling of hands or feet ○	lightheadedness / dizzy ○ racing / skipping heart beats ○ shortness of breath with exertion ○ difficulty breathing while lying down ○	NONE ○
RESPIRATORY	sputum ○ excessive snoring ○	wheezing ○ chronic cough ○ shortness of breath ○	NONE ○
GASTROINTESTINAL	abdominal bloating ○ diarrhea ○ constipation ○	loss of appetite ○ nausea ○ indigestion ○ abdominal pain ○	NONE ○
GENITOURINARY	inability to control bladder ○	blood in urine ○ frequent urination ○	NONE ○
MUSCULOSKELETAL	muscle weakness or cramps ○	arthritis ○ back pain ○	NONE ○
SKIN	excessive sweating ○	rash ○ itching ○	NONE ○
NEUROLOGIC	impaired speech ○ brief paralysis ○ poor memory ○	headaches ○ tingling ○ falling down ○ numbness ○	NONE ○
PSYCHIATRIC	unusual stress ○ eating disorder ○	anxiety ○ depression ○	NONE ○
ENDOCRINE	excessive thirst ○ excessive urination ○	overweight ○ thyroid problem ○	NONE ○
HEME/LYMPHATIC	abnormal bruising ○	enlarged lymph nodes ○	NONE ○
ALLERGIC/IMMUNOLOGIC	drug allergies ○	seasonal allergies ○	NONE ○