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 CURRENTLY are experiencing.

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

General	Lack of Appetite ◯	Night Sweats ◯	Unintentional Weight Loss (over 10 lbs) ◯	
	Tiredness ◯	Fever ◯	NONE ◯	
Head, Ears, Eyes, Nose & Throat	Wear Glasses ◯	Glaucoma ◯	Sleep Apnea ◯	Headache ◯
	Wear Contacts ◯	Hoarseness ◯	Decreased Hearing ◯	NONE ◯
Cardiovascular	Heart Stent ◯	Swelling of Hands or Feet ◯	Leg Cramps ◯	
	Fainting/Blacking Out ◯	Elevated Blood Pressure ◯	Chest Pain ◯	NONE ◯
Genitourinary	Blood in Urine ◯	Change in Urinary Stream ◯	Pelvic Pain ◯	
		Painful Urination ◯	Frequency ◯	NONE ◯
Neurological	Dizziness ◯	Loss of Consciousness ◯	Seizure ◯	
	Fainting ◯	Weakness in Extremities ◯	Difficult Speech ◯	NONE ◯
Endocrine	Cold Intolerance ◯	Heat Intolerance ◯	Excessive Thirst ◯	
			Excessive Urination ◯	NONE ◯
Musculoskeletal	Physical Disability ◯	Joint Stiffness ◯	Backache ◯	NONE ◯
Skin	Itching ◯	Rash ◯		NONE ◯
Respiratory	Chronic Cough ◯	Difficulty Breathing ◯	Wheezing ◯	NONE ◯
Psychiatric	Suicidal Thoughts ◯	Depression ◯	Anxiety ◯	NONE ◯
Blood	Easy Bruising ◯			NONE ◯
Breast	Breast Mass ◯	Breast Pain ◯		NONE ◯
Gastrointestinal	Nausea ◯	Abdominal Swelling ◯	Vomiting Blood ◯	Belching ◯
	Diarrhea ◯	Food/Milk Intolerance ◯	Abdominal Pain ◯	Black Stool ◯
	Bloating ◯	Get Full Quickly at Meals ◯	Painful Swallowing ◯	Laxative Use ◯
	Vomiting ◯	Change in Bowel Habits ◯	Difficulty Swallowing ◯	Blood in Stool ◯
	Constipation ◯	Pain with Bowel Movement ◯	Incontinence of Stool ◯	Gas/Flatulence ◯
	Heartburn ◯			NONE ◯

Has your stool tested positive for blood in the past 6 months? Yes ◯ No ◯