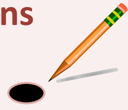
Print in Color or Grayscale Only
Using Adobe Acrobat Reader 8.0 or later

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 all symptoms you are CURRENTLY experiencing.

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

System	Symptoms	Symptoms	
General	change in appetite ◯ chills ◯ fatigue ◯	feeling well ◯ fever ◯ unintentional weight gain ◯ unintentional weight loss ◯	NONE ◯
Skin	rash ◯ slow healing sores ◯	wound or sore ◯ skin color changes ◯	NONE ◯
HEENT	headache ◯ change in vision ◯ flashes ◯ spots ◯	runny nose ◯ nasal congestion ◯ seasonal allergies ◯ sinus pain ◯ sore throat ◯	NONE ◯
Neck	neck pain ◯	stiff neck ◯ swollen glands ◯	NONE ◯
Respiratory	cough ◯	difficulty breathing ◯ wheezing ◯	NONE ◯
Breast	breast mass ◯	breast pain ◯	NONE ◯
Cardiovascular	chest pain ◯ difficulty breathing lying down ◯	palpitations ◯ shortness of breath ◯ swelling of extremitites ◯	NONE ◯
Gastrointestinal	abdominal pain ◯ constipation ◯ diarrhea ◯	heartburn ◯ indigestion ◯ nausea ◯ vomiting ◯	NONE ◯
Female Genitourinary	painful urination ◯ flank pain ◯	frequent urination ◯ urinary leakage ◯	NONE ◯
Male Genitourinary	change in libido ◯ difficulty with erection ◯ flank pain ◯	frequent urination ◯ difficulty starting or stopping stream ◯ nighttime urination ◯	NONE ◯
Musculoskeletal	back pain ◯ joint pain ◯	muscle cramps ◯ muscle pain ◯ muscle weakness ◯	NONE ◯
Neurological	dizziness ◯ numbness ◯	tingling or burning sensation ◯ walking or balance trouble ◯	NONE ◯
Psychiatric	anxiety ◯ depression ◯	daytime sleepiness ◯ insomnia ◯	NONE ◯
Endocrine	cold intolerance ◯ excessive thirst ◯	excessive urination ◯ heat intolerance ◯	NONE ◯
Hematology	abnormal bleeding ◯	easy bruising ◯	NONE ◯

SAMPLE

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