Do not write, stamp, punch holes or affix a sticker in this area. To reproduce, follow the printing instructions.

Direction of Feed

Review of Systems

Please answer every question

*Handwritten items must be entered **MANUALLY**. 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 you have no symptoms in a category, please mark "NONE".

MUSCULOSKELETAL

RIGHT ARM:	numbness	pain	tingling	weakness
LEFT ARM:	numbness	pain	tingling	weakness
RIGHT LEG:	numbness	pain	tingling	weakness
LEFT LEG:	numbness	pain	tingling	weakness

neck pain (cervical)
upper back pain (thoracic)
lower back pain (lumbar)
NONE

NEUROLOGICAL

disorientation
seizures
imbalance
headaches
stroke
dizziness
coordination
loss of consciousness
difficulty with speech
confusion
NONE

EYES

acute visual loss
blurred vision
double vision
loss of peripheral vision
wear glasses
wear contact lenses
eye pain
eye redness
cataracts
NONE

EARS, NOSE, THROAT, MOUTH

hearing loss
wear hearing aid
ringing in ear(s)
ear pain
ear infection
tongue numbness
dentures
swallowing
vocal cord paralysis
sinus headache
sore throat
mouth sores / ulcers
nasal congestion
nasal drainage
nose bleeds
inability to taste
inability to smell
NONE

RESPIRATORY

asthma
bronchitis
lung cancer
chronic cough
shortness of breath
blood in sputum
pneumonia
NONE

CARDIOVASCULAR

chest pain / angina
leg cramping
ankle swelling
irregular pulse
varicose veins
swelling in feet
swelling in hands
palpitations
NONE

ENDOCRINE

breast enlargement
nipple discharge
excessive thirst
excessive urination
hormone problems
fatigue
high blood pressure
diabetes
NONE

Weight gain?	yes	no
Weight loss?	yes	no
Enlargement of the hands?	yes	no
Enlargement of ring size?	yes	no
Enlargement of feet?	yes	no
Enlargement of shoe size?	yes	no
Impairment of sexual function?	yes	no
Decreased libido (sex drive)**?**	yes	no
Infertility?	yes	no
Stretch marks?	yes	no

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Review of Systems

Please answer every question

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HEMATALOGIC (blood)

chills ◯ fever ◯ hemophilia ◯ bruises easily ◯ blood transfusions ◯ bleeding easily ◯ **NONE** ◯

GASTROINTESTINAL

nausea ◯ vomiting ◯ diarrhea ◯ constipation ◯ colon cancer ◯ rectal bleeding ◯ blood in vomit ◯ indigestion ◯ jaundice ◯ bowel changes ◯ abdominal pain ◯ **NONE** ◯

PSYCHIATRIC

anxiety ◯ depression ◯ agitation ◯ hallucinations ◯ **NONE** ◯

INTEGUMENTARY / SKIN

skin disorders ◯ nail changes ◯ excessive dryness ◯ itching / rashes / sores ◯ hair changes ◯ changes in moles ◯ **NONE** ◯

GENITOURINARY

urinary tract infection ◯
blood in urine ◯
hesitancy ◯
inability to control urine ◯
pyelonephritis (kidney infection) ◯
difficulty urinating ◯
urgency ◯
painful urination ◯
kidney disease ◯
incontinence of urine ◯
incontinence of stool ◯
NONE ◯

Have you ever needed dialysis? yes ◯ no ◯

Can you tell when your bladder is full? yes ◯ no ◯

Can you sense (feel) **urine passing?** yes ◯ no ◯

Does your bladder feel empty following voiding? yes ◯ no ◯

Do you have to get up at night to urinate? yes ◯ no ◯

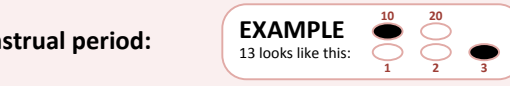
If yes, how many times?
1 ◯ 2 ◯ 3 ◯ 4 or more ◯

Decreased control of bowels? yes ◯ no ◯

FEMALES ONLY

Age at 1st menstrual period:

EXAMPLE
13 looks like this:

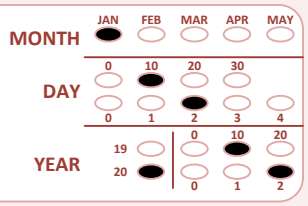


10 20 / 1 2 3 4 5 6 7 8 9

Are your menstrual periods regular? yes ◯ no ◯

Last menstrual period:

EXAMPLE
Jan. 12th, 2012
looks like this:



MONTH: JAN FEB MAR APR MAY JUN JUL AUG SEP OCT NOV DEC

DAY: 0 10 20 30 / 0 1 2 3 4 5 6 7 8 9

YEAR: 19 20 / 0 10 20 30 40 50 60 70 80 90 / 0 1 2 3 4 5 6 7 8 9

Number of pregnancies: 0 1 2 3 4 5 6 7 8 9 10 11+

Number of live births: 0 1 2 3 4 5 6 7 8 9 10 11+

INFECTIONS

Type: _____ **Type:** _____ **Type:** _____

Location: _____ **Location:** _____ **Location:** _____

Treatment: _____ **Treatment:** _____ **Treatment:** _____