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

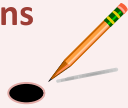
Review of Systems

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 only the symptoms you are CURRENTLY experiencing:

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

GENERAL

fevers ◯ | fatigue ◯
chills ◯ | weight loss ◯ | NONE ◯

EYES

eye pain ◯ | loss of vision ◯ | NONE ◯

EAR / NOSE / THROAT

impaired smell ◯ | difficulty swallowing ◯
loud snoring ◯ | hearing problems ◯ | NONE ◯

CARDIOVASCULAR

chest pain ◯ | palpitations ◯ | NONE ◯

RESPIRATORY

shortness of breath ◯ | cough ◯ | NONE ◯

GASTROINTESTINAL

abdominal pain ◯ | diarrhea ◯
constipation ◯ | nausea ◯ | NONE ◯

GENITOURINARY

bladder infections ◯ | urinary problems ◯ | NONE ◯

MUSCULOSKELETAL

muscle pain ◯ | swelling ◯
muscle cramps ◯ | weakness ◯ | NONE ◯

SKIN

skin rashes ◯ | dry skin ◯ | NONE ◯

NEUROLOGICAL

headaches ◯ | dizziness ◯
seizures ◯ | numbness ◯ | NONE ◯

PSYCHIATRIC

anxiety ◯ | depression ◯ | NONE ◯

HEMATOLOGIC / LYMPHATIC

bleeding problems ◯ | anemia ◯ | NONE ◯

OTHER SYMPTOMS / EXPLAIN

please list:______________________________

Thank you for your time in completing this questionnaire.

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

SAMPLE

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