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

Review of Systems

Please answer every question.

STAFF: Responses in boxes and handwritten items 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

Reason for today's visit: _____

_____

Date your problem began: _____

Describe how your accident / injury happened, or how the pain started: _____

_____

_____

Preferred phamacy: _____ **Phone #:** _____

Please mark all symptoms you are CURRENTLY experiencing.

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

General

chills ○
fever ○
unintentional weight gain ○
unintentional weight loss ○
NONE ○

Skin

brittle nails ○
changes in nails ○
new lesion(s) ○
skin color changes ○
NONE ○

Respiratory

cough ○
difficulty breathing on exertion ○
shortness of breath ○
NONE ○

Cardiovascular

chest pain ○
NONE ○

Musculoskeletal

atrophy ○
decreased range of motion ○
joint pain ○
joint redness ○
joint stiffness ○
joint swelling ○
muscle swelling ○
muscle weakness ○
NONE ○

Neurologic

burning ○
focal problems ○
numbness ○
seizures ○
stroke ○
swelling ○
tingling ○
NONE ○