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		recurring infections ○	
chills ○	night sweats ○	unintentional weight loss ○	
fever ○	persistent infections ○	unintentional weight gain ○	NONE ○
Eyes	glasses / contacts ○	visual disturbance ○	NONE ○
Ears, Nose and Throat	hearing loss ○	hoarseness ○	NONE ○
Cardiovascular	difficulty breathing on exertion ○	shortness of breath ○	
chest pain ○	palpitations ○	swelling hands / feet ○	NONE ○
Respiratory	difficulty breathing ○	shortness of breath ○	NONE ○
Gastrointestinal	bleeding ○	loss of bowel control ○	NONE ○
Female Genitourinary	painful intercourse ○	urinary urgency ○	
blood in urine ○	painful menstruation ○	urine leakage ○	
excessive urination at night ○	painful urination ○	vaginal discharge ○	
loss of urine control ○	pelvic pain ○	vaginal dryness ○	
menstrual irregularities ○	urinary frequency ○	vaginal itch or burning ○	NONE ○
Male Genitourinary			
blood in urine ○	impotence ○	urethral discharge ○	
change in urinary stream ○	painful urination ○	urinary frequency ○	
ejaculation difficulties ○	penis lesions ○	urinary urgency ○	
erection difficulties ○	testicular mass ○	urine leakage ○	
excessive urination at night ○	testicular pain ○	weak urine stream ○	NONE ○
Skin	hives ○	rash ○	
change in wart or mole ○	new sore / lesion ○	recurring sores ○	
dry skin ○	non-healing sores ○	skin ulcer ○	NONE ○
Neurologic	decreased memory ○	seizures ○	
	difficulty using hands ○	trouble walking ○	NONE ○
Psychiatric	anxiety ○	fearful ○	
	depression ○	frequent crying ○	NONE ○
Hematology / Lymphatic	easy bruising ○	excessive bleeding ○	NONE ○