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 only the symptoms you are CURRENTLY experiencing.

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

GENERAL	dizziness ○ fainting ○ fatigue ○	fever ○ weight gain ○ weight loss ○	**NONE** ○
EYES	glasses / contacts ○	visual disturbances ○	**NONE** ○
EAR, NOSE AND THROAT	hearing loss ○	seasonal allergies ○ sinus pain ○	**NONE** ○
CARDIOVASCULAR	chest pain ○ difficulty breathing on exertion ○	palpitations ○ shortness of breath ○ swelling hands / feet ○	**NONE** ○
RESPIRATORY	chronic cough ○ coughing blood ○	difficulty breathing ○ wheezing ○	**NONE** ○
MUSCULOSKELETAL	joint pain ○ joint swelling ○	muscle cramps / spasms ○ muscle weakness ○ stiffness ○	**NONE** ○
GASTROINTESTINAL	change in bowel habits ○ constipation ○	nausea ○ vomiting ○	**NONE** ○
SKIN	new sore / lesion ○	rash ○	**NONE** ○
NEUROLOGIC	falling down ○ headaches ○ numbness ○	poor balance ○ tingling ○ weakness ○	**NONE** ○
PSYCHIATRIC	anxiety ○	depression ○ suicidal thoughts ○	**NONE** ○
ENDOCRINE	excessive thirst ○	excessive urination ○ painful urination ○	**NONE** ○
HEME/LYMPHATIC	easy bruising ○	excessive bleeding ○	**NONE** ○
IMMUNOLOGIC	HIV exposure ○	persistent infection ○	**NONE** ○