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

Adult Review of Systems

Please answer every question

PLEASE PRINT PATIENT'S LAST NAME

PLEASE PRINT PATIENT'S FIRST NAME

PATIENT'S DATE OF BIRTH

Month Day Year

Marking Instructions

Please use a # 2 pencil
Fill in the complete oval as shown...

Please mark only the symptoms you CURRENTLY are experiencing.
Mark all that apply - if no symptoms, please mark "NONE."

General			
	fatigue ○	weight gain ○	NONE ○
Ear / Nose / Throat			
		hearing loss ○	
	ringing in ears ○	nasal congestion ○	
	allergies ○	hoarseness ○	NONE ○
Cardiovascular			
	edema ○	palpitations / fast heartbeat ○	NONE ○
Respiratory			
	chronic cough ○	difficulty breathing on exertion ○	NONE ○
Gastrointestinal			
	nausea ○	acid reflux / heartburn ○	NONE ○
Genital / Urinary			
	lack of sexual drive ○	excessive nighttime urination ○	NONE ○
Musculoskeletal			
		muscle pain ○	
	joint pain ○	swelling of extremities ○	NONE ○
Neurologic			
		memory loss ○	
	dizziness ○	tingling of extremities ○	
	headaches ○	difficulty with concentration ○	NONE ○
Psychiatric			
	depression ○	anxiety / nervousness ○	NONE ○
Endocrine			
	intolerance to cold ○	intolerance to heat ○	NONE ○