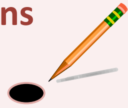
Print in Color or Grayscale Only
Using Adobe Acrobat Reader 8.0 or later

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 CURRENTLY are experiencing.

Mark all that apply ---- if no symptoms, please mark "NONE"

Category				
General	fever fatigue	weight loss weight gain	persistent infections	NONE
Eyes		visual disturbances	glasses/contacts	NONE
Ear, Nose, and Throat		hearing loss seasonal allergies	sinus pain oral ulcers	NONE
Cardiovascular	chest pain shortness of breath	palpitations swelling hands/feet	difficulty breathing on exertion	NONE
Respiratory	sleep apnea	difficulty breathing wheezing	chronic cough coughing blood	NONE
Musculoskeletal	joint pain	muscle pain	chronic back pain muscle weakness	NONE
Gastrointestinal	bloody stool vomiting change in bowel habits	constipation chronic diarrhea abdominal pain	hemorrhoids excessive gas indigestion	nausea NONE
Skin	dry skin	rash	new sore/lesion	NONE
Neurologic	fainting decreased memory	difficulty with speech numbness trouble walking	arm or leg weakness seizures headaches	NONE
Psychiatric	anxiety	depression	suicidal thoughts	NONE
Endocrine		hot flashes	cold intolerance	NONE
Heme/Lymphatic	clotting problems	blood clots in the past	easy bruising excessive bleeding	NONE
Female Genitourinary (Women Only)		urinary frequency urine leakage	pelvic pain blood in urine	NONE
Male Genitourinary (Men Only)	painful urination	testicular pain impotence	blood in urine urine leakage	NONE

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

SAMPLE

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