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	fatigue	weight loss weight gain	persistent infections fever	NONE
Eyes		visual disturbances	glasses / contacts	NONE
Ear, Nose, and Throat	hearing loss	seasonal allergies	sinus pain oral ulcers	NONE
Cardiovascular	color changes in hands or feet non-healing wound or ulcer pain in legs	leg pain when walking numbness in legs swelling in legs	palpitations chest pain shortness of breath difficulty breathing on exertion	NONE
Respiratory	difficulty breathing	wheezing	chronic cough coughing blood	NONE
Breast	mass / lump	breast pain	nipple discharge	NONE
Gastrointestinal	nausea vomiting change in bowel habits	constipation chronic diarrhea abdominal pain	indigestion bloody stool hemorrhoids excessive gas	NONE
Musculoskeletal	joint pain	muscle pain	muscle weakness	NONE
Skin	dry skin change in wart or mole	rash hives	new sore / lesion skin ulcer	NONE
Neurologic	fainting decreased memory	numbness trouble walking	seizures headaches	NONE
Psychiatric	change in sleep pattern	frequent crying depression	anxiety fearful	NONE
Endocrine	hair changes	hot flashes	cold intolerance heat intolerance	NONE
Heme/Lymphatic	easy bruising	excessive bleeding	gland problems	NONE

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

SAMPLE

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