Do not write, stamp, punch holes or affix a sticker in this area.

Direction of Feed

Review of Systems

Please answer every question

To reproduce, follow the printing instructions. Do not fold this form.

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."

General	chills	appetite loss	
fever	night sweats	weight gain over past year	
fatigue	frequent headaches	weight loss	NONE
Eyes	discharge	cataracts	
blurring	eye pain	impaired vision – 1 eye	
double vision	floppy eyelids	impaired vision – both eyes	
irritation	require glasses	light sensitivity	NONE
Ear / Nose / Throat	ringing in ears	nose bleeds	
jaw joint pain	choking on food	sore throat	
earache	hearing loss	hoarseness	
ear discharge	nasal congestion	trouble swallowing	NONE
Cardiovascular	lightheadedness	palpitations	
chest pain	passing out or fainting	shortness of breath with exertion	
skipped heartbeats	swelling in hands or legs	heart racing	NONE
Respiratory	chronic cough	shortness of breath	
	excessive sputum	coughing up blood	
	wheezing	chest discomfort	NONE
Gastrointestinal		excessive appetite	
nausea	constipation	vomiting blood	
vomiting	abdominal pain	blood in or black stools	
diarrhea	acid reflux	change in bowel habits	
abdominal bloating	indigestion	yellowish skin color	NONE
Genital / Urinary	kidney pain	blood in urine	
	burning with urination	nighttime urination	NONE
Musculoskeletal	joint stiffness	muscle pain	
	joint swelling	neck pain	
back pain	muscle cramps	loss of strength	
joint pain	muscle weakness	arthritis	NONE
Skin		poor wound healing	
itching	dryness	suspicious lesions	
rash	changes in skin color	history of skin cancer	NONE
Neurologic			
transient paralysis	dizziness	difficulty speaking	
numbness in legs / arms	headaches	history of head trauma	
seizures	poor balance	history of loss of consciousness	
tremors	falling down	difficulty with concentration	
tingling sensation	memory loss	fainting	NONE
Psychiatric	depression	impaired concentration	
	anxiety / nervousness	memory loss	NONE
Endocrine intolerance to cold	excessive hunger	excessive liquid consumption	
intolerance to heat	excessive thirst	thyroid problem	
post menopausal	excessive urination	hot flashes	NONE
Hematologic / Lymphatic	abnormal bruising	abnormal bleeding tendency	
	enlarged lymph nodes	history of anemia	NONE
Allergy / Immunologic		hives	
	frequent infections	hay fever / nasal allergies	
	chronic fatigue syndrome	HIV exposure	NONE

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