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

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...

Mark all symptoms that you are CURRENTLY experiencing.

If you have no symptoms within a category, please mark "NONE."

General	chills	weight loss	night sweats	
	fever	weight gain	appetite loss	
	fatigue	feeling sick	excessive perspiration	NONE
Eyes	double vision	"halos" around lights	discharge	
	vision loss - 1 eye	blurring	eye irritation	
	vision loss – both	light sensitivity	eye pain	NONE
Respiratory	cough	excessive sputum	coughing up blood	
	wheezing	excessive snoring	sleep disturbances due to breathing	NONE

please fold on dotted line

Ear, Nose and Throat		ear discharge	ringing in ears	
	earache	nosebleeds	hoarseness	
	decreased hearing	nasal congestion	sore throat	NONE
Cardiovascular			difficulty breathing lying down	
		leg cramps with exertion	shortness of breath with exertion	
		swelling of hands or feet	bluish discoloration of lips or nails	
		chest pain or discomfort	racing / skipping heartbeats	NONE
Gastrointestinal		excessive appetite	nausea	
	gas	indigestion	diarrhea	
	vomiting	constipation	difficulty swallowing	
	vomiting blood	yellowish skin color	dark / tarry stools	
	abdominal pain	change in bowel habits	blood in stools	NONE
Genitourinary	pelvic pain	trouble starting urinary stream	painful urination	
	blood in urine	inability to empty bladder	genital sores	
	urinary urgency	inability to control bladder	missed periods	
	urinary frequency	night time urination	excessively heavy periods	NONE
Musculoskeletal			muscle cramps	
	joint pain	stiffness	muscle weakness	
	joint swelling	back pain	muscle aches	NONE
Endocrine		heat intolerance	excessive thirst	
	cold intolerance	excessive hunger	excessive urination	NONE

please fold on dotted line

Skin			rash	
	itching	suspicious lesions	changes in color of skin	
	dryness	poor wound healing	changes in nail beds	NONE
Neurologic	headaches	falling down	tingling	
	poor balance	fainting	disturbances in coordination	
	numbness	memory loss	difficulty with concentration	
	tremors	weakness	sensation of room spinning	NONE
Psychiatric		anxiety	depression	NONE
Heme / Lymphatic		bleeding	abnormal bruising	
		skin discoloration	enlarged lymph nodes	NONE
Allergic / Immunologic			seasonal allergies	
		persistent infections	HIV exposure	NONE

What is your CURRENT smoking status? (Please mark one.)

current (every day) | previous
current (some days) | NEVER