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

Direction of Feed

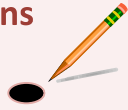
Family Medicine Review of Systems

Please answer every question

To reproduce, follow the printing instructions. Fold only on the dotted lines.

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 all symptoms you are CURRENTLY experiencing. Mark all that apply.
If you have no symptoms in a category, please mark "NONE".

GENERAL: fatigue ○ fever ○ persistent infections ○ weight loss ○ weight gain ○ **NONE** ○

EYES: visual disturbances ○ glasses / contacts ○ **NONE** ○

EAR, NOSE AND THROAT: sore throat ○ congestion ○ hearing loss ○ seasonal allergies ○ ringing in ears ○ ear pain ○ sinus pain ○ oral ulcers ○ **NONE** ○

please fold on dotted line

CARDIOVASCULAR: chest pain ○ palpitations ○ difficulty breathing on exertion ○ swelling hands / feet ○ shortness of breath ○ **NONE** ○

RESPIRATORY: difficulty breathing ○ wheezing ○ chronic cough ○ coughing blood ○ **NONE** ○

BREAST: breast pain ○ mass / lump ○ nipple discharge ○ **NONE** ○

FEMALE GENITOURINARY (Women Only): pelvic pain ○ urine leakage ○ blood in urine ○ painful urination ○ frequent urination ○ increased urinary urgency ○ excessive urination at night ○ vaginal dryness ○ vaginal discharge ○ vaginal itch / burning ○ painful intercourse ○ painful menstruation ○ menstrual irregularities ○ **NONE** ○

MALE GENITOURINARY (Men Only): painful urination ○ frequent urination ○ testicular pain ○ penile lesions ○ blood in urine ○ impotence ○ urethral discharge ○ testicular mass ○ change in urinary stream ○ excessive urination at night ○ increased urinary urgency ○ urine leakage ○ **NONE** ○

MUSCULOSKELETAL: joint pain ○ joint stiffness ○ joint swelling ○ muscle pain ○ muscle weakness ○ **NONE** ○

please fold on dotted line

GASTROINTESTINAL: nausea ○ vomiting ○ indigestion ○ constipation ○ chronic diarrhea ○ abdominal pain ○ blood in stool ○ hemorrhoids ○ excessive gas ○ change in bowel habits ○ **NONE** ○

SKIN: dry skin ○ change in wart / mole ○ rash ○ hives ○ new sore / lesion ○ skin ulcer ○ **NONE** ○

NEUROLOGIC: fainting ○ headaches ○ numbness ○ trouble walking ○ seizures ○ decreased memory ○ **NONE** ○

PSYCHIATRIC: anxiety ○ change in sleep pattern ○ frequent crying ○ depression ○ fearful ○ **NONE** ○

ENDOCRINE: hair changes ○ hot flashes ○ cold intolerance ○ heat intolerance ○ **NONE** ○

HEME / LYMPHATIC: excessive bleeding ○ easy bruising ○ gland problems ○ **NONE** ○

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SAMPLE

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