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

↑ Direction of Feed ↑

Review of Systems

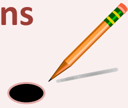
Please answer every question

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"

Section				
General	chills ◯	weight loss ◯	persistent infections ◯	
	fever ◯	weight gain ◯	fatigue ◯	NONE ◯
Eyes		redness ◯	visual disturbances ◯	
		itching ◯	glasses / contacts ◯	NONE ◯
Ear, Nose, and Throat		nasal congestion ◯	sore throat ◯	
	runny nose ◯	hoarseness ◯	sinus pain ◯	
	ear pain ◯	headache ◯	seasonal allergies ◯	NONE ◯
Cardiovascular			palpitations ◯	
		chest pain ◯	swelling hands / feet ◯	NONE ◯
Respiratory			difficulty breathing ◯	
		cough ◯	wheezing ◯	NONE ◯
Breast	mass / lump ◯	breast pain ◯	nipple discharge ◯	NONE ◯
Gastrointestinal			indigestion ◯	
	nausea ◯	constipation ◯	blood in stool ◯	
	vomiting ◯	diarrhea ◯	hemorrhoids ◯	
	change in bowel habits ◯	abdominal pain ◯	bloating ◯	NONE ◯
Female Genitourinary (Women Only)		pelvic pain ◯	painful urination ◯	
	urinary frequency ◯	vaginal discharge ◯	blood in urine ◯	
	urinary urgency ◯	vaginal itch or burning ◯	menstrual irregularities ◯	
	excessive urination at night ◯	painful intercourse ◯	urine leakage ◯	NONE ◯
Male Genitourinary (Men Only)		urinary frequency ◯	testicular mass ◯	
	painful urination ◯	urinary urgency ◯	testicular pain ◯	
	change in urinary stream ◯	urine leakage ◯	penile lesions ◯	
	excessive urination at night ◯	urethral discharge ◯	blood in urine ◯	NONE ◯
Musculoskeletal		back pain ◯	joint pain ◯	
		muscle pain ◯	muscle weakness ◯	NONE ◯
Skin		rash ◯	new sore / lesion ◯	NONE ◯
Neurologic	fainting ◯	numbness ◯	seizures ◯	
	decreased memory ◯	trouble walking ◯	headaches ◯	NONE ◯
Psychiatric	anxiety ◯	frequent crying ◯	fearful ◯	
	change in sleep pattern ◯	depression ◯		NONE ◯
Endocrine			cold intolerance ◯	
		heat intolerance ◯	hot flashes ◯	NONE ◯
Heme/Lymphatic	easy bruising ◯	excessive bleeding ◯	gland problems ◯	NONE ◯

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SAMPLE

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