

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"

General	fever <input type="radio"/>	weight loss <input type="radio"/>	persistent infections <input type="radio"/>	NONE <input type="radio"/>
	fatigue <input type="radio"/>	weight gain <input type="radio"/>		
Eyes		visual disturbances <input type="radio"/>	glasses/contacts <input type="radio"/>	NONE <input type="radio"/>
Ear, Nose, and Throat		hearing loss <input type="radio"/>	sinus pain <input type="radio"/>	NONE <input type="radio"/>
		seasonal allergies <input type="radio"/>	oral ulcers <input type="radio"/>	
Cardiovascular	chest pain <input type="radio"/>	palpitations <input type="radio"/>	difficulty breathing on exertions <input type="radio"/>	NONE <input type="radio"/>
	shortness of breath <input type="radio"/>	swelling hands/feet <input type="radio"/>		
Respiratory		difficulty breathing <input type="radio"/>	chronic cough <input type="radio"/>	NONE <input type="radio"/>
		wheezing <input type="radio"/>	coughing blood <input type="radio"/>	
Breast	mass/lump <input type="radio"/>	breast pain <input type="radio"/>	nipple discharge <input type="radio"/>	NONE <input type="radio"/>
Gastrointestinal	nausea <input type="radio"/>	constipation <input type="radio"/>	bloody stool <input type="radio"/>	indigestion <input type="radio"/>
	vomiting <input type="radio"/>	chronic diarrhea <input type="radio"/>	hemorrhoids <input type="radio"/>	
	change in bowel habits <input type="radio"/>	abdominal pain <input type="radio"/>	excessive gas <input type="radio"/>	NONE <input type="radio"/>
Female Genitourinary (Women Only)	urinary frequency <input type="radio"/>	vaginal dryness <input type="radio"/>	painful urination <input type="radio"/>	pelvic pain <input type="radio"/>
	urinary urgency <input type="radio"/>	vaginal discharge <input type="radio"/>	painful menstruation <input type="radio"/>	blood in urine <input type="radio"/>
	excessive urination at night <input type="radio"/>	vaginal itch or burning <input type="radio"/>	menstrual irregularities <input type="radio"/>	
		painful intercourse <input type="radio"/>	urine leakage <input type="radio"/>	NONE <input type="radio"/>
Male Genitourinary (Men Only)	painful urination <input type="radio"/>	urinary frequency <input type="radio"/>	testicular mass <input type="radio"/>	urine leakage <input type="radio"/>
	change in urinary stream <input type="radio"/>	urinary urgency <input type="radio"/>	testicular pain <input type="radio"/>	
	excessive urination at night <input type="radio"/>	impotence <input type="radio"/>	penile lesions <input type="radio"/>	
		urethral discharge <input type="radio"/>	blood in urine <input type="radio"/>	NONE <input type="radio"/>
Musculoskeletal	joint pain <input type="radio"/>	muscle pain <input type="radio"/>	muscle weakness <input type="radio"/>	NONE <input type="radio"/>
Skin	dry skin <input type="radio"/>	rash <input type="radio"/>	new sore/lesion <input type="radio"/>	
	change in wart or mole <input type="radio"/>	hives <input type="radio"/>	skin ulcer <input type="radio"/>	NONE <input type="radio"/>
Neurologic	fainting <input type="radio"/>	numbness <input type="radio"/>	seizures <input type="radio"/>	
	decreased memory <input type="radio"/>	trouble walking <input type="radio"/>	headaches <input type="radio"/>	NONE <input type="radio"/>
Psychiatric	anxiety <input type="radio"/>	frequent crying <input type="radio"/>	fearful <input type="radio"/>	
	change in sleep pattern <input type="radio"/>	depression <input type="radio"/>		NONE <input type="radio"/>
Endocrine	hair changes <input type="radio"/>	heat intolerance <input type="radio"/>	cold intolerance <input type="radio"/>	
			hot flashes <input type="radio"/>	NONE <input type="radio"/>
Heme/Lymphatic	easy bruising <input type="radio"/>	excessive bleeding <input type="radio"/>	gland problems <input type="radio"/>	NONE <input type="radio"/>