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

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

FIRST VISIT Mark all symptoms that pertain to you.
REPEAT VISIT Mark only the symptoms that you have experienced since your last visit.
Mark all that apply ---- if no symptoms, please mark "NONE."

General			
chills	weight loss	night sweats	
fever	weight gain	appetite loss	
excessive perspiration	feeling sick	fatigue	NONE
Eyes			
double vision	"halos" around lights	discharge	
vision loss - 1 eye	blurring	eye irritation	
vision loss – both	light sensitivity	eye pain	NONE
Ear, Nose, and Throat	earache	ringing in ears	
ear discharge	nosebleeds	hoarseness	
decreased hearing	nasal congestion	sore throat	NONE
Cardiovascular			
		shortness of breath with exertion	
swelling of hands or feet	leg cramps with exertion	bluish discoloration of lips or nails	
chest pain or discomfort	difficulty breathing lying down	racing / skipping heartbeats	NONE
Respiratory			
excessive sputum	cough	sleep disturbances due to breathing	
wheezing	excessive snoring	coughing up blood	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	bloody stools	NONE
Genitourinary			
painful urination	trouble starting urinary stream	pelvic pain	
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
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
Endocrine			
	heat intolerance	excessive thirst	
cold intolerance	excessive hunger	excessive urination	NONE
Heme / Lymphatic		abnormal bruising	
bleeding	skin discoloration	enlarged lymph nodes	NONE
Allergic / Immunologic			
persistent infections	seasonal allergies	HIV exposure	NONE