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

| Α | TIE | NT | S D | ATE | OF | ВІ | RTH |
|---|-----|-----|-----|-----|----|----|-----|
| | | 1 1 | | | ΙГ | | |

th Day Year

Please mark only the symptoms you **CURRENTLY** are experiencing. Mark all that apply ---- if no symptoms, please mark "NONE."

| GENERAL | | | ciaht lass | | | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------|------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------|--|--|
| | fever 🔾 | fatigue 🔘 | weight loss O weight gain O | NONE | | |
| | c quit wi | ARETTE SMOKING: current (every day) urrent (some days) thin the last month ore than 1 year ago never | SMOKING CESSATION: not applicable want to quit now / need help not yet ready to quit do not want to quit | | | |
| EYES visual d | isturbances 🔾 | glasses 🔾 | contacts 🔾 | NONE O | | |
| EAR, NOSE, AND TH | | hearing loss | seasonal allergies 🔾 | NONE (| | |
| CARDIAC faint / pass out for no reason shortness of breath with walking chest pain lightheadedness shortness of breath with lying down chest discomfort palpitations swelling of feet, ankles, or hands dizzy heart murmur difficulty breathing on exertion VASCULAR Foot, calf, buttock, hip, or thigh discomfort when walking which is relieved by rest? Discoloration (blue, black, or pale) of feet or toes? | | | | | | |
| | Slow | healing wounds, infections, Diminish | or ulcers on feet or toes? Oned pulses on foot (feet)? | NONE | | |
| | y breathing O | cough C snoring C | CPAP Owheezing | NONE ○ | | |
| GASTROINTESTINA | | vomiting bloody stool | indigestion abdominal pain | NONE _ | | |
| GENITOURINARY | | urinary frequency cex | erectile dysfunction Cessive urination at night Cessive | NONE O | | |
| MUSCULOSKELETA | L joint pain 🔘 | muscle pain 🔾 | muscle weakness | NONE | | |
| SKIN | rash 🔾 | hives 🔾 | skin ulcer varicose veins | NONE (| | |
| NEUROLOGIC decreas | ed memory 🔾 | numbness 🔾 | unsteady walking | NONE (| | |
| PSYCHIATRIC | anxiety 🔾 | frequent crying | change in sleep pattern change in sleep pattern change in sleep pattern change depression change depression change in sleep pattern change in sleep pa | NONE ○ | | |
| ENDOCRINE elevated | blood sugar | cold intolerance | heat intolerance | NONE O | | |
| HEME / LYMPHATIO | C | easy bruising | excessive bleeding | NONE | | |