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. 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	chills ◯	fatigue ◯	night sweats ◯	
	fever ◯	loss of appetite ◯	weight gain ◯	
			weight loss ◯	**NONE** ◯
SKIN		hives ◯	rash ◯	
	change in wart or mole ◯	jaundice ◯	skin ulcer ◯	
	dry skin ◯	new sore/lesion ◯	poor wound healing ◯	**NONE** ◯

please fold on dotted line

HEENT (Head, Eyes, Ears, Nose, Throat)	earache ◯	hoarseness ◯	seasonal allergies ◯	
	ear ringing ◯	nose bleeds ◯	sinus pain ◯	
	hearing loss ◯	oral ulcers ◯	sore throat ◯	
	glasses/contacts ◯	visual disturbances ◯	yellow eyes ◯	**NONE** ◯
RESPIRATORY		coughing blood ◯	snoring ◯	
	chronic cough ◯	difficulty breathing ◯	wheezing ◯	**NONE** ◯
BREAST		breast pain ◯	mass/lump ◯	
		breast skin change ◯	nipple discharge ◯	**NONE** ◯
CARDIOVASCULAR			difficulty breathing lying down ◯	
		chest pain ◯	palpitations ◯	
		racing heart rate ◯	shortness of breath ◯	
		leg cramps ◯	swelling hands/feet ◯	**NONE** ◯
GASTROINTESTINAL		constipation ◯	hemorrhoids ◯	
	abdominal pain ◯	change in bowel habits ◯	indigestion ◯	
	bloating ◯	difficulty swallowing ◯	nausea ◯	
	bloody stool ◯	excessive gas ◯	rectal pain ◯	
	chronic diarrhea ◯	getting full early ◯	vomiting ◯	**NONE** ◯
GENITOURINARY (Men Only)		blood in urine ◯	painful urination ◯	
		change in urinary stream ◯	urinary frequency ◯	
		excessive urination at night ◯	urinary urgency ◯	
		impotence ◯	urinary leakage ◯	**NONE** ◯

please fold on dotted line

GENITOURINARY (Women Only)			pelvic pain ◯	
	excessive urination at night ◯		urinary frequency ◯	
	painful urination ◯		urinary urgency ◯	**NONE** ◯
MUSCULOSKELETAL	back pain ◯	muscle pain ◯	stiffness ◯	
	joint pain ◯	muscle weakness ◯	swelling ◯	**NONE** ◯
NEUROLOGIC		numbness ◯	headaches ◯	
	confusion/ decreased memory ◯	seizures ◯	fainting ◯	
		tingling ◯	trouble walking ◯	
		tremors ◯	weakness ◯	**NONE** ◯
PSYCHIATRIC	anxiety ◯	bipolar ◯	fearful ◯	
	change in sleep pattern ◯	depression ◯	frequent crying ◯	**NONE** ◯
ENDOCRINE	cold intolerance ◯	hair changes ◯	hot flashes ◯	
	excessive hunger ◯	heat intolerance ◯	new diabetes ◯	**NONE** ◯
HEME/LYMPHATIC	blood thinners ◯	HIV ◯	gland problems ◯	
	easy bruising ◯	excessive bleeding ◯	persistent infection ◯	**NONE** ◯