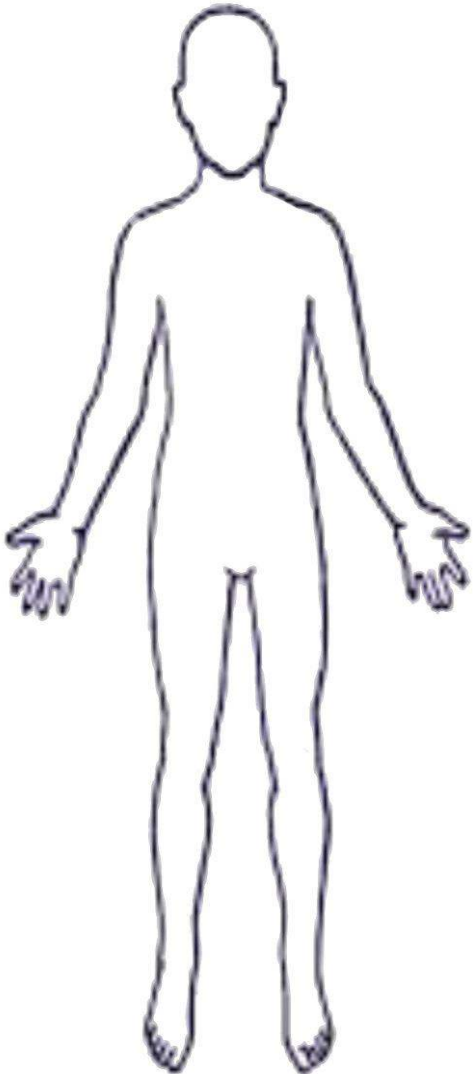


Symptom Review

Please detail any symptoms you have noted related to the reason(s) for your visit today.



Head/Neurologic _____

Eyes _____

Ears _____

Nose/Sinus _____

Throat/Neck _____

Heart _____

Lung _____

Esophagus/Stomach _____

Kidney/Bladder _____

Colon _____

Muscles _____

Bones/Joints _____

Skin _____

General _____

Patient Signature or Initials