REVIEW OF SYSTEMS

PLEASE COMPLETE THIS ENTIRE PAGE!

Use additional paper if needed – bring with you at time of your appointment!

THANK YOU!

Please write down any changes in your health since your last visit with us:

_____

_____

Please list current medications or bring current medication list with you at time of appointment. Please indicate if refills are needed and name of Pharmacy used:

_____

_____

_____

Please list any allergies: (especially medications)

_____

_____

_____

_____

Please circle answers to the following:

Recent weight loss	Yes / No	Leg pain with walking:	Yes/No
Chills	Yes/ No	Wheezing	Yes/No
Night sweats	Yes/ No	Cough	Yes/No
Generalized weakness	Yes/No	Bloody Cough	Yes/No
Blurry vision	Yes/ No	Constipation	Yes/No
Double Vision	Yes/ No	Diarrhea	Yes/No
Hearing Loss	Yes/ No	Black/tarry stools	Yes/No
Dizziness	Yes/ No	Painful urination	Yes/No
Lightheadedness	Yes/ No	Incontinence	Yes/No
Nose Bleeds	Yes / No	Blood in urine	Yes/No
Sore Throats	Yes / No	Rashes	Yes/No
Hoarse Voice	Yes / No	Itching	Yes /No
Chest Pain or Pressure	Yes / No	Passing Out	Yes/No
Palpitations (heart skipping)	Yes / No	Weakness on 1 side of body	Yes/No
Shortness of Breath	Yes / No	Numbness	Yes/No
Short of breath lying flat	Yes / No	Tingling feeling	Yes/ No
Waking up short of breath	Yes / No	Excessive Urination	Yes/No
Swelling of ankles / legs	Yes / No	Excessive thirst	Yes/No