REVIEW OF SYSTEMS

Name _____ Birth Date: _____ Today's Date: _____

Phone Number: _____ Marital Status: ☐ Married ☐ Divorced ☐ Single ☐ Widowed

Employer _____ Reason for today's visit: _____

I. Please list any operations and/or hospitalizations since your last visit with us. Date:

1.	
2.	
3.	

II. Please list any current prescription medications and/or over the counter meds, vitamins, or supplements that you are taking.

Name	Dosage		Name	Dosage
1.			5.	
2.			6.	
3.			7.	
4.			8.	

III. ALLERGIES

- **Are you allergic to *Latex*?** ☐ **YES** ☐ **NO**
- **Do you have any known *drug* allergies?** ☐ **YES** ☐ **NO**

If yes, please explain:_____

- **Do you have any *food* allergies?** ☐ **YES** ☐ **NO**

If yes, please explain:_____

IV. What was the date of your last menstrual cycle? _____

*****PLEASE ALSO COMPLETE THE BACK SIDE OF THIS FORM**

V. Please place an (X) beside the appropriate box if any of the following apply to you now, in the past or often.

1. Constitutional	Presently	Past	Comments	7. Genitourinary	Presently	Past	Comments
				Decreased Sex Drive	☐	☐	
Weight loss	☐	☐		Blood in urine	☐	☐	
Weight gain	☐	☐		Pain with urination	☐	☐	
Fever	☐	☐		Urgency	☐	☐	
Fatigue	☐	☐		Frequency of urine	☐	☐	
Hot flashes	☐	☐		Incomplete emptying	☐	☐	
Night sweats	☐	☐		Leaking of urine	☐	☐	
				Irregular periods	☐	☐	
				Painful Intercourse	☐	☐	
2. Eyes				**8. Musculoskeletal**			
Vision changes	☐	☐		Back pain	☐	☐	
Impaired vision	☐	☐		Joint pain	☐	☐	
Spots before eyes	☐	☐		Joint swelling	☐	☐	
3. Ear, Nose, Throat & Mouth				**9. Skin & Breast**			
				Breast Pain	☐	☐	
Headaches	☐	☐		Breast mass or lump	☐	☐	
Ringing in ears	☐	☐		Nipple rash	☐	☐	
Sinus problems	☐	☐		Nipple discharge	☐	☐	
Sore throat	☐	☐		Skin rash or ulcers	☐	☐	
Mouth sores	☐	☐		Vaginal discharge	☐	☐	
Seasonal Allergies	☐	☐					
4. Cardiovascular				**10. Neurological**			
Chest pain	☐	☐		Dizziness	☐	☐	
Shortness of breath	☐	☐		Seizures	☐	☐	
Swelling of legs	☐	☐		Numbness & Tingling	☐	☐	
Irregular Heartbeat	☐	☐		Loss of balance	☐	☐	
5. Respiratory				**11. Psychiatric**			
Wheezing	☐	☐		Depression	☐	☐	
Chronic cough	☐	☐		Anxiety	☐	☐	
Spitting up blood	☐	☐		Mood Swings	☐	☐	
6. Gastrointestinal				**12. Endocrine**			
Diarrhea, frequent	☐	☐		Dry Skin	☐	☐	
Nausea	☐	☐		Abnormal Thirst	☐	☐	
Vomiting	☐	☐					
Constipation	☐	☐					
Bloody stools	☐	☐					

***Pharmacy:** _____ **Location:** _____ **Phone:** _____

Signature of Patient: _____ **Date:** _____/_____/_____

PLEASE DO NOT WRITE BELOW THIS LINE

Account #_____ **Witness's Signature:** _____