**Review of Systems**

**Patient’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Preferred Pharmacy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Fill in appropriate circles completely and return to front desk**

General/Constitutional Cardiovascular

Recent fever/sweats ⃝ Yes ⃝ No Chest pains w/exertion ⃝ Yes ⃝ No

Unexplained weight loss/gain ⃝ Yes ⃝ No Palpitations ⃝ Yes ⃝ No

 Irregular heartbeat ⃝ Yes ⃝ No

Ophthalmologic

Change in vision ⃝ Yes ⃝ No Breast

Eye pain ⃝ Yes ⃝ No Breast lump ⃝ Yes ⃝ No

Discharge ⃝ Yes ⃝ No Nipple discharge ⃝ Yes ⃝ No

Ear/Nose/Throat Gastrointestinal

Ringing in the ears ⃝ Yes ⃝ No Abdominal pain ⃝ Yes ⃝ No

Sore Throat ⃝ Yes ⃝ No Rectal bleeding ⃝ Yes ⃝ No

Sinus pain ⃝ Yes ⃝ No Heartburn/reflux ⃝ Yes ⃝ No

 Nausea/vomiting/diarrhea ⃝ Yes ⃝ No

Endocrine

 Genitourinary

Excessive thirst ⃝ Yes ⃝ No

Cold/heat tolerance ⃝ Yes ⃝ No Blood in urine ⃝ Yes ⃝ No

 Leaking urine ⃝ Yes ⃝ No

Respiratory Difficulty urinating ⃝ Yes ⃝ No

 Discharge: Penis/Vagina ⃝ Yes ⃝ No

Cough/wheeze ⃝ Yes ⃝ No Incontinence ⃝ Yes ⃝ No

Coughing blood ⃝ Yes ⃝ No

Chest congestion/edema ⃝ Yes ⃝ No Skin

Shortness of breath ⃝ Yes ⃝ No

 Rash ⃝ Yes ⃝ No

Musculoskeletal New or change in mole ⃝ Yes ⃝ No

Muscle/joint pain ⃝ Yes ⃝ No Blood/Lymphatic

Recent back pain ⃝ Yes ⃝ No

Leg cramps ⃝ Yes ⃝ No Unexplained lumps ⃝ Yes ⃝ No

 Easy bruising/bleeding ⃝ Yes ⃝ No

Neurological

 Psychiatric

Headaches ⃝ Yes ⃝ No

Dizziness ⃝ Yes ⃝ No Anxiety/stress ⃝ Yes ⃝ No

Walking problems ⃝ Yes ⃝ No Sleep problems ⃝ Yes ⃝ No

Memory loss ⃝ Yes ⃝ No Depressed mood ⃝ Yes ⃝ No

**Patient’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ D.O.B: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Preferred Pharmacy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Chief Complaint: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Vitals**

BP \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ht. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Wt. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Temp.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

O2\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Respiration\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Pulse\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Current Medications Dose Times per day**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**Allergies or reactions to medications, foods or other substances: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**Personal Medical History**

**□** Heart Disease □ High Blood Pressure □ High Cholesterol

 Specific Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Diabetes □ Thyroid problem

□ Asthma/Lung Disease □ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Kidney disease

□ Psychiatric □ Seasonal/Animal Allergies □ Cancer (specify):\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Surgical History: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Hospitalizations (month/year/reason):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**Family History**

□ Alcoholism □ Depression/Suicide □ High cholesterol

□ Cancer (specify type) \_\_\_\_\_\_\_\_ □ Genetic Disorder □ High blood pressure

□ Heart Disease □ Diabetes □ Asthma/COPD

**□** Stroke □ Bleeding or clotting disorder □ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Social History**

Tobacco Use ⃝ Yes ⃝ No ⃝ Quit Alcohol Use ⃝ Yes ⃝ No ⃝ Quit

⃝ Current Smoker: Packs/day \_\_\_\_\_ # of years\_\_\_\_\_\_ Is your alcohol use a concern for you or others?

Other tobacco use: ⃝ Pipe ⃝ Cigar ⃝ Snuff ⃝ Chew ⃝ Yes ⃝ No

Are you interested in quitting? ⃝ Yes ⃝ No