

Patient Name _____

Date _____

Baseline Review of Systems Questionnaire

Are you currently being treated or have sought treatment for any of the following:

NO YES ?

NO YES ?

GENERAL WELL BEING

Fever, Weight Loss/Gain _____

NEUROLOGICAL

Headaches _____

Migraines _____

Seizures / Convulsions _____

EARS, NOSE, MOUTH, THROAT

Allergies / Hay Fever _____

Sinus Infections _____

Dry Throat / Mouth _____

GASTROINTESTINAL

Diarrhea/Constipation _____

OTHER SYSTEMIC DISORDERS

Diabetes _____

Thyroid/Other Glands _____

HIV / AIDS _____

Hepatitis/Jaundice _____

Herpes Simplex _____

Skin Disorders _____

Auto-immune Disorders _____

Other Allergic Disorders _____

PREGNANT? Y / N _____ **Y / N** _____ **Y / N** _____ **Y / N** _____
Exam Date Exam Date Exam Date Exam Date

If you have answered YES to any of the above or have a condition not listed, please explain.

Primary Care

Dr's Name: _____ **Phone** _____ **Fax** _____

Pharmacy Name: _____ **Phone** _____ **Fax** _____

Pharmacy Address: _____

Doctor's Signature Date (ROS-Word /Feb, 2009)

Reviewed and updated Reviewed and updated Reviewed and updated Reviewed and updated Reviewed and updated

This handy form can help you use medicine safely. Keep it up-to-date, and bring it with you to each hospital or doctor's visit.

**MY MEDICATION RECORD (PRESCRIPTION, NON-PRESCRIPTION,
OVER-THE-COUNTER, HERBAL)**

NAME: _____ BIRTH DATE: ____/____/____

ALLERGIES: _____

MEDICINES YOU ARE ALLERGIC TO: _____

MEDICATION NAME	WHAT IS IT FOR?	DOSE	HOW OFTEN?	PRESCRIBED BY: (PHONE #)
<i>Example: Aspirin</i>	<i>Headache</i>	<i>200 mg</i>	<i>Once per day</i>	<i>Dr. John Doe, 123-456-7890</i>

For more information on safe and effective medicine use, ask your pharmacist or contact:



*American Society of Health-System Pharmacists
7272 Wisconsin Avenue
Bethesda, MD 20814
(301) 664-8799
www.SafeMedication.com*

A community service brought to you by the doctors and staff of:

Central Phoenix Eye Care
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(my medication list 02/2023)