Patient Name _____ Date _____

Current Medications:
Please list ALL medications you currently take. Please include ANY vitamins, herbal supplements, over-the-counter medications as well as pain medications, muscle relaxers If you do not take any medications, please write "none".

☐ No changes from previous visit	

Review of Systems *(please circle any current or ongoing problems listed below)*	
Constitutional	Fevers • chills • weight loss • weight gain • fatigue • nights sweats
Eyes	Vision loss • double vision • blurred vision • glaucoma • cataracts • glasses
ENT	Hearing loss • hearing aids • runny nose • hoarseness of the voice • swallowing problems
Cardiovascular	Chest pain • irregular heart beat • cardiovascular disorder • swelling of the legs
Respiratory	Shortness of breath • cough • oxygen use
Gastrointestinal	Heartburn • abdominal pain • nausea • vomiting • dark or bloody in stool diarrhea • constipation • incontinence of stool
Genitourinary	Painful or burning urination • blood in urine • difficulty starting or stopping urination • urinary retention • incontinence of urine • increased frequency
Hematology	Bleeds easy • swollen glands or lymph nodes
Endocrinology	Heat intolerance • cold intolerance • excessive thirst • excessive hunger
Neurological	Headaches • problems walking • balance problems • loss of continuousness • muscle weakness • extremity numbness/tingling •
Musculoskeletal	Neck pain • thoracic pain • low back pain • extremity pain • decreased range of motion of joint(s) Joint swelling
Skin	Rash • non-healing sores • skin growth
Reproductive	Erectile dysfunction • decreased sexual drive • menopause
Psychiatric	Memory loss • depression • anxiety • post-traumatic stress disorder