Name:_____ Date:_____

Have you been in the hospital since your last visit? Yes / No

Review of systems and Medication

Cardiovascular
_____Murmur
_____Irregular Heart Rhythm
_____Palpitations
_____Squeezing of the chest
_____Chest Pain
_____Chest tightness or discomfort
_____Shortness of breath
_____Shortness of breath with exertion
_____other:_____
Ears, Nose
_____Hearing loss
_____Ringing in ears
_____Abnormal mucous membranes
Eyes
_____Blurred or Double vision
_____Contacts or Glasses
Psychiatric
_____Anxiety problems
_____Depressive symptoms
_____Personality or Mood changes
Integumentary
_____Edema - Swelling
_____Sweating
_____Bruising
_____Skin lesions
_____Skin cancer
_____Rash or itching on skin
Gastrointestinal
_____Abdominal pain
_____Weight gain
_____Weight loss
_____Change in appetite
_____Nausea or Vomiting
_____Diarrhea or Constipation
_____Indigestion or Heartburn
_____Reflux
Musculoskeletal
_____Arthritis
_____Back or Neck pain
_____Leg pain
_____Arm pain
_____Gout
Neurological
_____Gait disturbance trouble walking
_____Seizures
_____Confusion or Memory loss
_____Weakness or Fatigue
_____Numbness or Tingling
_____Headaches
_____Dizziness
_____Syncope (Passed out)
_____Swallowing difficulties
_____Difficulties in Speech
Respiratory
_____Congestion or Wheezing
_____Cough
Genitourinary
_____Incontinence
_____Frequent urination
_____pain or burning with urination
_____Blood in Urine

Please list your Medications

Name of Medication	Strength/MG	Frequency	Refill needed
_____	_____MG	_____	Yes / No
_____	_____MG	_____	Yes / No
_____	_____MG	_____	Yes / No
_____	_____MG	_____	Yes / No
_____	_____MG	_____	Yes / No
_____	_____MG	_____	Yes / No
_____	_____MG	_____	Yes / No
_____	_____MG	_____	Yes / No
_____	_____MG	_____	Yes / No
_____	_____MG	_____	Yes / No
_____	_____MG	_____	Yes / No
_____	_____MG	_____	Yes / No