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Review of Systems

Patient Name: ______________________ DOB: ____________ Today's Date: ____________

Preferred Pharmacy: ____

Have you been experiencing any of the following symptoms during the last two weeks?

GASTROINTESTINAL

Nausea	No	Yes
Vomiting	No	Yes
Heartburn	No	Yes
Black stool	No	Yes
Red blood in stool	No	Yes
Abdominal pain	No	Yes
Constipation	No	Yes
Diarrhea	No	Yes
Loss of appetite	No	Yes

HEENT

Sore throat	No	Yes
Hoarseness	No	Yes
Headaches	No	Yes
Visual changes	No	Yes

CARDIOVASCULAR

Abnormal heart rhythm	No	Yes
Chest pain	No	Yes
Palpitations (strong beats)	No	Yes

GENERAL

Fatigue	No	Yes
Unexplained weight loss	No	Yes
Night sweats	No	Yes

SKIN

Rash	No	Yes
Itching	No	Yes
Suspicious skin lesions	No	Yes

RESPIRATORY

Cough	No	Yes
Shortness of breath on exertion	No	Yes
Shortness of breath at rest	No	Yes
Wheezing	No	Yes

NEUROLOGICAL

Seizures	No	Yes
Numbness	No	Yes
Weakness (loss of extremity use)	No	Yes

MUSCULOSKELETAL

Joint pain	No	Yes
Joint swelling	No	Yes
Muscle pain	No	Yes

PSYCHIATRIC

Difficulty sleeping	No	Yes
Depression	No	Yes
Anxiety	No	Yes
Mania	No	Yes

GENITOURINARY

Frequent urination	No	Yes
Painful urination	No	Yes

*If female, date of last menstrual cycle: __________

Oral Health

Dry Mouth	No	Yes
Mouth Pain	No	Yes

Date of last dental exam: ____________________

MEN

In the past year, have you had 5 or more alcoholic drinks in one day? No Yes

In the past year, have you used a recreational drug or used a prescription medication for non-medical reasons? No Yes

Little interest or pleasure in doing things? No Yes
Feeling down, depressed, or hopeless? No Yes

WOMEN

In the past year, have you had 4 or more alcoholic drinks in one day? No Yes

In the past year, have you used a recreational drug or used a prescription medication for non-medical reasons? No Yes

Little interest or pleasure in doing things? No Yes
Feeling down, depressed, or hopeless? No Yes