

Review of systems

Do you now or have you had any problems related to the following systems? Circle Yes or No

Please explain any yes answer in space provided

Constitutional symptoms

Fever Y N
 Chills Y N
 Headache Y N
 Other _____

Eyes

Blurred vision Y N
 Double vision Y N
 Pain Y N
 Other _____

Allergic/Immunologic

Hay Fever Y N
 Drug Allergies Y N
 Other _____

Neurological

Tremors Y N
 Dizzy spells Y N
 Numbness/tingling Y N
 Other _____

Endocrine

Excessive Thirst Y N
 Too Hot/Cold Y N
 Tired Sluggish Y N
 Other _____

Gastrointestinal

Abdominal Pain Y N
 Nausea/Vomiting Y N
 Indigestion/Heartburn Y N
 Other _____

Cardiovascular

Chest pain Y N
 Varicose Veins Y N
 High blood Pressure Y N
 Other _____

Integumentary

Skin rash Y N
 Boils Y N
 Persistent itch Y N
 Other _____

Musculoskeletal

Joint Pain Y N
 Neck Pain Y N
 Back Pain Y N
 Other _____

Ear Nose & Throat

Ear Infection Y N
 Sore Throat Y N
 Sinus Problems Y N
 Other _____

Genitourinary

Urine retention Y N
 Painful urination Y N
 Urinary frequency Y N
 Other _____

Respiratory

Wheezing Y N
 Frequent Cough Y N
 Shortness of breath Y N
 Other _____

Hematologic/Lymphatic

Swollen glands Y N
 Blood clotting problems Y N
 Other _____

Psychologic

Are you generally satisfied
 with your life Y N
 Do you feel severely depressed Y N
 Have you considered Suicide Y N
 Other _____

Physician use only: (Comments/Notes)

Answers	Level of service
0 - 1	1 or 2
2 - 9	3
10 +	4 or 5

Advanced Directive? Y N

Living Will Y N

Pharmacy Name: _____ Pharmacy Phone # _____

Pharmacy FAX # _____

Physician Signature _____

Date ____/____/____