Patient Name: _____

RETURN PATIENT FORM

Please list any changes in medical history or medications:

_____

_____

__

REVIEW OF SYSTEMS: Please circle or list problems in each body system.

Constitutional: fever weight gain weight loss appetite change night sweats fatigue chills

Eyes: blurry double vision vision loss tearing redness pain sensitivity to light glaucoma

Ears, Nose, Mouth, Throat: hearing loss ringing in ears ear pain nasal congestion nasal drainage nosebleeds mouth/throat irritation tooth problem

Cardiovascular: chest pain/pressure heart racing palpitations sweating leg swelling high/low blood pressure

Pulmonary: cough yellow/green sputum blood in sputum shortness of breath wheezing

Gastrointestinal: nausea vomiting diarrhea constipation pain blood in stool or vomitus heartburn difficulty swallowing

Genitourinary: incontinence abnormal bleeding abnormal discharge urinary frequency urinary hesitancy pain impotence sexual problem infection urinary retention

Musculoskeletal: pain stiffness joint redness/warmth arthritis back pain weakness muscle wasting sprain/fracture

Neuro: headache weakness dizziness change in voice change in taste change in vision change in hearing loss/change sensation trouble walking balance problem coordination problem shaking speech problem

Endocrine: cold or heat intolerance blood sugar problem weight gain/loss missed periods hot flashes/sweats change in body hair change in libido increased thirst increased urination

Heme/Lymph: swelling bleeding problem anemia bruising enlarged lymph node

Allergic/Immunologic: itch post-nasal drip watery/itchy eyes nasal drainage immunosuppressed