**REVIEW OF SYSTEMS**

Please write down any changes in your health since your last visit with us:

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Please list current medications or bring current medication list with you at time of appointment.

Please indicate if refills are needed and name of Pharmacy used:

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Please list any allergies: **(especially medications)**

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| **Please circle answers to the following:** | |  | | |  |
| Recent weight loss | **Yes/No** | | Leg pain with walking: | **Yes/No** | | |
| Chills | **Yes/No** | | Wheezing | **Yes/No** | | |
| Night sweats | **Yes/No** | | Cough | **Yes/No** | | |
| Generalized weakness | **Yes/No** | | Bloody Cough | **Yes/No** | | |
| Blurry vision | **Yes/No** | | Constipation | **Yes/No** | | |
| Double Vision | **Yes/No** | | Diarrhea | **Yes/No** | | |
| Hearing Loss | **Yes/No** | | Black/tarry stools | **Yes/No** | | |
| Dizziness | **Yes/No** | | Painful urination | **Yes/No** | | |
| Lightheadedness | **Yes/No** | | Incontinence | **Yes/No** | | |
| Nose Bleeds | **Yes/No** | | Blood in urine | **Yes/No** | | |
| Sore Throats | **Yes/No** | | Rashes | **Yes/No** | | |
| Hoarse Voice | **Yes /No** | | Itching | **Yes /No** | | |
| Chest Pain or Pressure | **Yes/No** | | Passing Out | **Yes/No** | | |
| Palpitations (heart skipping) | **Yes/No** | | Weakness on 1 side of body | **Yes/No** | | |