**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** |