

Patient \_\_\_\_\_

**ALLERGIES/TYPE OF REACTION**     No known drug allergies

Latex       Tape      1. \_\_\_\_\_      3. \_\_\_\_\_  
 Other: (please specify)      2. \_\_\_\_\_      4. \_\_\_\_\_

**REVIEW OF SYSTEMS**

*(Please circle any of the following you currently experience)*

**General**

Weight Loss  
Weight Gain  
Fever  
Fatigue

**Eyes**

Pain  
Discharge  
Light Sensitivity  
Blurred vision

**ENT**

Sore throat  
Hoarseness  
Ear ringing  
Nose bleeds

**Respiratory**

Wheezing  
Cough  
Shortness of breath

**Cardiovascular**

Chest pain  
Fainting  
Feet swelling  
Palpitations  
Pacemaker

**Gastrointestinal**

Abdominal pain  
Nausea  
Vomiting  
Diarrhea  
Blood in stool

**Genitourinary**

Frequency  
Hesitancy  
Flank pain  
Painful urination  
Blood in urine

**Neurological**

Headache  
Confusion  
Numbness  
Slurred speech  
Seizure

**Musculoskeletal**

Joint swelling  
Joint redness  
Joint pain  
Gait problems

**Skin/breast**

Rash  
Itching  
Sores  
Abscess  
Discharge

**Endocrine**

Excess sweat  
Excess thirst  
Excess hot  
Excess cold

**Hematologic/Lymphatic**

Bleeding tendencies  
Lymph node swelling  
Easy bruising

**Psychologic**

Anxiety  
Depression  
Severe stress  
Panic

Explanation or other \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**FOR FEMALES:**

Are you pregnant? \_\_\_\_\_ Date of last menstrual period \_\_\_\_\_  Menstrual irregularity

**FOR MALES:**

Do you experience impotency? \_\_\_\_\_ Erectile problems \_\_\_\_\_

**IMMUNIZATIONS:**

flu \_\_\_\_\_ pneumonia \_\_\_\_\_ others \_\_\_\_\_  
Date Date Date