PATIENT NAME: _____ Date:_____

Please indicate if you are having any current problems, signs or symptoms in any of the following areas:

✓		✓	
☐	General Wellness	☐	Neurological
☐	Eyes	☐	Allergies
☐	Skin	☐	Reproductive/Urinary
☐	Ears, Nose, Throat	☐	Thyroid/Endocrine
☐	Stomach/Digestion	☐	Psychiatric
☐	Lungs/Breathing	☐	Blood/Lymph
☐	Heart/Circulation	☐	Other
☐	Dizziness	☐	Giddiness
☐	Trouble Sleeping	☐	Memory
☐	Chest Pains	☐	Fatigue
☐	Muscles/Joints/Bones	☐	Other

Physician Comments - Review of systems

☐All other systems negative **ROS**: 1 prob pertinent, 2-9 extended, 10+ complete

Have you seen any other doctors since your last visit here? YES NO WHEN? ___/__//___

Reason you saw the other doctor?

Reason for Today's Visit:

Please list any allergies you have:

Current Medications

Since your last visit, please note any changes to: Marital Status, Job, Smoking or Drinking