Established Patient Sheet

Local Pharmacy Name_____ Street/City _____

Mail Order Pharmacy_____

Height _____ Weight_____

What are today's complaints/symptoms?_____

Any NEW medications since last visit?_____

Review of Systems- Please Circle ALL that apply TODAY

General	Feeling Well	Weight Loss	Fever	Night Sweats
Skin	Bruising	Itchy Skin	Rash (es)	
HEENT	Blurred Vision	Double Vision	Dizziness	Hearing Loss
	Ear Discharge	Ear Pain	Ringing in Ears	Seasonal Allergies
Neck	Swollen Glands			
Respiratory	Cough	Snoring	Wheezing	Bloody Sputum
Cardiovascular	Chest Pain	Leg Pain/Swelling	Short of Breath	
Gastrointestinal	Black/Tarry Stool	Constipation	Diarrhea	Heartburn
Genitourinary	Urinary Complaints	Prostate Issues		
Musculoskeletal	Muscle Pain			
Neurological	Headaches	Weak in arms/legs		
Hematology	Abnormal Bleeding	Easy Bruising	Nosebleeds	