

RETURN PATIENT FORM**DATE:** _____

NAME: _____	AGE: _____
PRIMARY CARE PHYSICIAN: _____	

REASON FOR THIS APPOINTMENT:

ALLERGIES: _____

ALL MEDICATIONS (include dose and frequency; also include over the counter and herbal medications):

Since your last visit, any changes or updates in:

Past Medical or Surgical History: _____

Social History: marital status: _____ children: _____ alcohol use: _____

tobacco use: _____ occupation: _____

Family History: _____

REVIEW OF SYSTEMS (Please circle as applicable):

Constitutional	weight loss / gain loss of appetite fevers fatigue
Eyes	eye pain blurry vision eye redness
ENMT	hearing loss sinus congestion sore throat hoarseness mouth lesions / ulcers
Allergic	sneezing runny nose postnasal drip
Respiratory	cough wheezing shortness of breath
Cardiovascular	chest pain palpitations irregular heartbeat
Gastrointestinal	heartburn nausea vomiting difficulty swallowing (solids / liquids) pain on swallowing
	abdominal pain diarrhea constipation blood in stools stool accidents/incontinence
Genitourinary	blood in urine pain with urination frequent urination nocturnal urination urinary accidents/ incontinence
	Women: irregular/painful menstrual periods heavy menstrual periods
Musculoskeletal	muscle pains joint swelling joint pains back pain
Neurologic	numbness / tingling weakness headache dizziness loss of consciousness
Skin	itchiness redness rash hives
Endocrine	heat intolerance cold intolerance excessive thirst
Hematologic	easy bleeding easy bruising
Psychiatric	depression anxiety insomnia excessive stress