

# Review of Systems

## Fox & Brantley Internal Medicine

916 E. High Street ▪ Suite 1 ▪ Charlottesville

Name \_\_\_\_\_ Date \_\_\_\_\_

### Concerns for today's visit:

*Please circle any symptoms that you are having presently:*

Headaches	Vision Changes	Thyroid problems	Chest Pain
Skin rash	Decreased hearing	High blood sugar	Shortness of breath
Skin sores	ringing in ears	Increased thirst	Palpitations
Fatigue	Dizziness	Increased urination	Fainting spells
Fever	Sinus problems		Leg swelling
Loss of Appetite	Hoarseness		Wheezing / coughing
Abdominal pain	Painful urination	Arthritis	Seizures
Heartburn	Blood in urine	Pain in joints	Tremors or shaking
Nausea or vomiting	Kidney stones	Back pain	Numbness in hands/feet
Constipation	Problems urinating		Weakness in arm/leg
Diarrhea	Leakage of urine		Memory Problems
Hemorrhoids	Urgent urination		
Blood in stools	Sexual Dysfunction		
Problems swallowing			

Has there been any change in your family medical history since your last visit? **Yes / No**

Has there been any change in your living situation or personal health habits since your last visit? **Yes / No**

Do you smoke? **Yes / No** If so how many packs per day? \_\_\_\_\_

Do any medications need to be refilled? \_\_\_\_\_ 1 Mth / 3 Mth / Oth \_\_\_\_\_  
\_\_\_\_\_ 1 Mth / 3 Mth / Oth \_\_\_\_\_  
\_\_\_\_\_ 1 Mth / 3 Mth / Oth \_\_\_\_\_  
\_\_\_\_\_ 1 Mth / 3 Mth / Oth \_\_\_\_\_

Which Pharmacy: \_\_\_\_\_

### STAFF SECTION:

CC/HPI: \_\_\_\_\_

Weight \_\_\_\_\_ Height \_\_\_\_\_ T \_\_\_\_\_ BP \_\_\_\_\_ P \_\_\_\_\_ RR \_\_\_\_\_ POX% \_\_\_\_\_

Any NEW drug allergies since last visit? \_\_\_\_\_

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