(307) 237-5510
Fax: (307) 237-0607
770 East 2nd Street
Casper, WY 82601

Patient Review of Systems

Please complete this form before today's appointment, and **only check boxes if these symptoms apply to your visit TODAY.** If you do not have any complaints, check the box at the bottom of the page. Please sign your name after you have verified that the information you have provided is correct.

Patient Name: ______________________ DOB: ______________ Date: ____________

General	☐ Weight Loss ☐ Weight Gain ☐ Fever ☐ Fatigue ☐ Sleep Disturbances
Psychological/Neurological	☐ Depression ☐ Fainting ☐ Seizures ☐ Numbness ☐ Headache
Eyes/ Ears/Mouth	☐ Vision Changes ☐ Glasses/Contacts ☐ Allergies ☐ Congestion ☐ Ringing in Ears
Chest	☐ Hand/Ankle Swelling ☐ Chest Pain ☐ Palpitations ☐ Shortness of Breath ☐ Difficulty Breathing ☐ Wheezing ☐ Coughing Blood ☐ Chronic Cough ☐ Breast Pain ☐ Brest Mass/Lump ☐ Nipple Discharge
Stomach and Intestines	☐ Nausea/Vomiting ☐ Bloody Stool ☐ Constipation ☐ Diarrhea ☐ Excessive Gas ☐ Hemorrhoids ☐ Difficulty Controlling Bowel ☐ Abdominal Pain
Urinary	☐ Frequency/Urgency ☐ Incomplete Bladder Emptying ☐ Leaking Urine ☐ Bloody Urine ☐ Burning/Pain
Vaginal	☐ Itching/Burning ☐ Discharge ☐ Dryness ☐ Painful Intercourse ☐ Pelvic Pain ☐ Abnormal/Painful Periods ☐ Abnormal Bleeding
Endocrine	☐ Heat/Cold Intolerance ☐ Hair Loss/ Growth ☐ Hot Flashes ☐ Night Sweats
Muscles/Bones	☐ Muscle Pain ☐ Muscle Weakness ☐ Joint Pain

☐ I have read everything in the categories above, ***and do not have any complaints today***.

The above information is correct to the best of my knowledge: ______________________________
Signature of Patient

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Review of systems was reviewed and discussed with patient at today's visit.

Signature of Provider:____Date:__________________________________