Patient Name: _____ Date: _____

Review of Systems: Please circle YES or NO below for each one

General / Constitutional:

Itching:	YES	NO
Loss of Appetite:	YES	NO
Weight Loss:	YES	NO
Weight Gain:	YES	NO
Chills:	YES	NO
Fever:	YES	NO

HEENT:

Vision Change:	YES	NO
Laser Surgery:	YES	NO
Cough:	YES	NO
Hearing Loss:	YES	NO

Endocrine/Hem/Oncology/Integument:

Skin Rash:	YES	NO
Bruises:	YES	NO
Lumps or Masses:	YES	NO

Respiratory:

Shortness of Breath:	YES	NO
Wheezing:	YES	NO

Cardiovascular:

Chest Pains:	YES	NO
Poor Circulation:	YES	NO
Swelling of Legs:	YES	NO

Gastrointestinal:

Nausea or Vomiting:	YES	NO
Constipation:	YES	NO
Diarrhea:	YES	NO

Genitourinary:

Blood in Urine:	YES	NO
Painful Urination:	YES	NO
Urination at night:	YES	NO
Kidney Stones:	YES	NO
Protein in urine:	YES	NO

Changes in urine flow or amount? YES NO

Do you use any Advil, Tylenol, Aleve, etc? YES NO

Musculoskeletal:

Body Aches:	YES	NO
Joint Pain:	YES	NO

Neurologic:

Burning of feet or finger	YES	NO
Weakness:	YES	NO
Tingling/Numbness:	YES	NO

Psychiatric:

Sleeping Problems:	YES	NO
Anxiety:	YES	NO
Depressed Mood:	YES	NO

Who is your Primary Care Physician? _____

What is the name of your pharmacy? _____

Have you been activated for the SKHC Patient Portal? YES NO

Please provide the front desk staff with your email address to receive access information to logon to SKHC Patient Portal to obtain your visit summary, lab results, prescription refill requests, etc.