# TH&V REVIEW OF SYSTEMS PROGRESS NOTE

**DATE:** ______________

**PATIENT NAME:** ______________________________ **DOB:** ______________________

**PRIMARY CARE PHYSICIAN:** ______________________ **REFERRING PHYSICIAN:** ______________________

**PHARMACY NAME:** ________________ **PHARMACY ADDRESS:** ______________________

**PREFERRED LANGUAGE:** ________________ **RACE:** ______________________

**ETHNICITY (CIRCLE ONE): HISPANIC OR LATINO NON-HISPANIC OR LATINO OTHER OR UNDETERMINED**

Please check as many of the following **NEW** symptoms that you have experienced

- ☐ Anxiety
- ☐ Asthma
- ☐ Blood in stool
- ☐ Blood in urine
- ☐ Chest heaviness
- ☐ Chest pain
- ☐ Chest tightness
- ☐ Cough
- ☐ Depression
- ☐ Dizziness
- ☐ Edema/leg swelling
- ☐ Fatigue/weakness
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Joint pain
- ☐ Leg pain with walking/exercising
- ☐ Lightheadedness
- ☐ Muscle pain or weakness
- ☐ Numbness/tingling in extremities
- ☐ Pain between shoulder blades/ jaw/arms with exertion or exercise
- ☐ Palpitations
- ☐ Shortness of breath
- ☐ Shortness of breath while lying down
- ☐ Significant weight change
- ☐ Skin rash
- ☐ Sleep disorder/apnea
- ☐ Stomach pain after eating

☐ **DENY ALL OF THE ABOVE (if nothing has changed since your last visit, please mark this box)**

**LAST FLU VACCINE** (Month: ____________ Year: __________)

**LAST PNEUMONIA VACCINE (only if age 65 or older)** (Month: ____________ Year: __________)

**DO YOU HAVE A MEDICAL POWER OF ATTORNEY?** YES __________ NO __________

If "yes" and you are 65 or older please provide the following: Name ____________________ Phone Number ____________________

**SINCE YOUR LAST VISIT** have you had any of the following?

Please check "Yes" or "No" and provide details in the space provided.

| | Yes | No | |
|---|---|---|---|
| New medication allergies? | ☐ | ☐ | If yes, please list: ____________ |
| **Hospitalizations?** | ☐ | ☐ | **When & why:** ____________ |
| New illness or diagnosis? | ☐ | ☐ | Name of illness/diagnosis: ____________ |
| New lab or diagnostic test? | ☐ | ☐ | Name of lab/test: ____________ |
| Change in Social history? | ☐ | ☐ | Explain: ____________ |
| Do you smoke? | ☐ | ☐ | Packs per day: ____________ Years? ____________ |
| Do you drink alcohol? | ☐ | ☐ | Amount per day: ____________ Type? ____________ |
| Caffeine use? | ☐ | ☐ | Amount per day: ____________ |
| Drug use? | ☐ | ☐ | If yes, what type of substance? ____________ |
| Exercise? | ☐ | ☐ | Times per week: ________ Type: ____________ |
| Change in family history? | ☐ | ☐ | Explain: ____________ |

______________________________ ______________________________

**Patient Signature** **Date**

| For Office Use Only | Pulse/Rhythm | Respirations | Weight/BMI | Temp | HT | Notes |
|---|---|---|---|---|---|---|
| | | | | | | |
| MA Initials: | Blood Pressure | Supine | Sitting | Standing | | |
| | Right Arm | | | | | |
| | Left Arm | | | | | |