

Patient Name _____

Date _____

Baseline Review of Systems Questionnaire

Are you currently being treated or have sought treatment for any of the following:

NO YES ?

NO YES ?

GENERAL WELL BEING

Fever, Weight Loss/Gain _____

NEUROLOGICAL

Headaches _____

Migraines _____

Seizures / Convulsions _____

EARS, NOSE, MOUTH, THROAT

Allergies / Hay Fever _____

Sinus Infections _____

Dry Throat / Mouth _____

GASTROINTESTINAL

Diarrhea/Constipation _____

OTHER SYSTEMIC DISORDERS

Diabetes _____

Thyroid/Other Glands _____

HIV / AIDS _____

Hepatitis/Jaundice _____

Herpes Simplex _____

Skin Disorders _____

Auto-immune Disorders _____

Other Allergic Disorders _____

PREGNANT? Y / N _____

Exam Date

Y / N _____

Exam Date

Y / N _____

Exam Date

Y / N _____

Exam Date

If you have answered YES to any of the above or have a condition not listed, please explain.

Primary Care

Dr's Name: _____ **Phone** _____ **Fax** _____

Pharmacy Name: _____ **Phone** _____ **Fax** _____

Pharmacy Address: _____

Doctor's Signature

Date

(ROS-Word /Feb, 2009)

Reviewed and updated

Reviewed and updated

Reviewed and updated

Reviewed and updated

Reviewed and updated