Office Visit Flowsheet

Riverview MEDICAL GROUP

Name: _____ Date of birth: _____

Primary care physician: _____ Referring physician: _____

Changes in medical/family history since last visit: _____

_____

New problems to discuss: _____

_____

Review of systems: (Please circle any problems you wish to discuss today)

GEN: fatigue, night sweats, unexpected weight change, sleep problems, smoking, excess alcohol, drug problem

SKIN: rash, itching, changed skin growth

HEENT: vision changes, eye pain, hearing problems, hoarseness

RESP: chronic cough, shortness of breath, coughing up blood

CARDIO: chest pain, fast or irregular heartbeat, swelling in legs, passing out

GI: abdominal pain, nausea, vomiting, heartburn, constipation, diarrhea, change in bowel habits, black or bloody stools

GU: breast lump, menstrual problems, incontinence, painful urination, blood in urine, vaginal/penile discharge, sexual problems, STDs

MS: back pain, joint/limb pain, joint swelling

NEU: headaches, dizzy, tingling in arms/legs

PSY: family/marital problems, depressed, anxious

ENDO: low blood sugar, heat/cold intolerance, losing weight

HEMO: unusual bruising, bleeding