MEDICATION FLOW SHEET

PATIENT: _____ **HYPERSENSITIVE TO:** _____

EYE MEDICATIONS										
GENERAL MEDICATIONS										

Name: _____ Date: _____

REVIEW OF SYSTEMS: If you are currently having any problems in the following areas, circle and explain (if necessary).

Fever, unexplained weight loss ❑ None

Explain: _____

Hearing loss, ringing, dry mouth, loss of smell, difficulty swallowing ❑ None

Explain: _____

Chest pain, palpitations, shortness of breath, exercise intolerance ❑ None

Explain: _____

Difficulty breathing, productive cough, wheezing ❑ None

Explain: _____

Nausea, vomiting, diarrhea, constipation ❑ None

Explain: _____

Frequency, burning or bleeding on urination, kidney stones ❑ None

Explain: _____

Muscle pain, joint pain or swelling ❑ None

Explain: _____

Skin: itching, rash, infection ulcer ❑ None

Explain: _____

Dizziness, light-headedness, fainting, seizures, tremors ❑ None

Explain: _____

Disorientation, anxiety, hallucinations ❑ None

Explain: _____

Fatigue, nervousness, hair loss ❑ None

Explain: _____

Easy bruising or bleeding, lymph node swelling or tenderness ❑ None

Explain: _____

Recurrent infections, hayfever, hives, food allergy ❑ None

Explain: _____

This form was completed by: ❑ patient ❑ family ❑ staff ❑ other

To be completed by physician: History reviewed: _____ , M.D.

Date: _____