Systems Review

Name:	Date of birth:
As you review the following list, please FILL IN NO OR YES for those problems that have significantly affected you.	

	No	Yes		No	Yes		No	Yes
Constitutional			Ears-Nose-Mouth-Throat (cont.)			Gastrointestinal		
Recent weight gain	O	O	Sores in mouth	O	O	Nausea	O	O
Recent weight loss	O	O	Loss of taste	O	O	Vomiting of blood or coffee ground material	O	O
Fatigue	O	O	Dryness of mouth	O	O	Stomach pain relieved by food or milk	O	O
Weakness	O	O	Frequent sore throats	O	O	Jaundice	O	O
Fever	O	O	Hoarseness	O	O	Increasing constipation	O	O
Eyes			Difficulty in swallowing	O	O	Persistent diarrhea	O	O
Pain	O	O	Cardiovascular			Blood in stools	O	O
Redness	O	O	Pain in chest	O	O	Black stools	O	O
Loss of vision	O	O	Irregular heart beat	O	O	Heartburn	O	O
Double or blurred vision	O	O	Sudden changes in heartbeat	O	O	Genitourinary		
Dryness	O	O	High blood pressure	O	O	Difficult urination	O	O
Feels like something in eye	O	O	Heart murmurs	O	O	Pain or burning on urination	O	O
Itching eyes	O	O	Respiratory			Blood in urine	O	O
Ears-Nose-Mouth-Throat			Shortness of breath	O	O	Cloudy, "smoky" urine	O	O
Ringing in ears	O	O	Difficulty in breathing at night	O	O	Pus in urine	O	O
Loss of hearing	O	O	Swollen legs or feet	O	O	Discharge from penis/vagina	O	O
Nosebleeds	O	O	Cough	O	O	Getting up at night to pass urine	O	O
Loss of smell	O	O	Coughing up blood	O	O	Vaginal dryness	O	O
Dryness in nose	O	O	Wheezing (asthma)	O	O	Rash/ulcers	O	O
Runny nose	O	O				Sexual difficulties	O	O
Sore tongue	O	O				Prostate trouble	O	O
Bleeding gums	O	O						

Systems Review

Name:	Date of birth:
As you review the following list, please FILL IN NO OR YES for those problems that have significantly affected you.	

	No	Yes
For women only:		
Age when periods began:		
Periods regular?	O	O
How many days apart:		
Date of last period: / /		
Date of last pap: / /		
Bleeding after menopause	O	O
Number of pregnancies:		
Number of miscarriages:		
Musculoskeletal		
Morning stiffness	O	O
Lasting how long? _____min _____hrs		
Joint pain	O	O
Muscle weakness	O	O
Muscle tenderness	O	O
Joint swelling	O	O
List all joints affected in the last 6 months.		
Date of last mammogram: / /		
Date of last tuberculosis test: / /		

	No	Yes
Integumentary (skin and/or breast)		
Easy bruising	O	O
Redness	O	O
Rash	O	O
Hives	O	O
Sun sensitive (sun allergy)	O	O
Tightness	O	O
Nodules/bumps	O	O
Hair loss	O	O
Color change in hands or feet in the cold	O	O
Neurological		
Headaches	O	O
Dizziness	O	O
Fainting	O	O
Muscle spasm	O	O
Loss of consciousness	O	O
Sensitivity or pain of hands and/or feet	O	O
Memory loss	O	O
Night sweats	O	O
Date of last eye exam: / /		
Date of last bone densitometry (DEXA scan): / /		

	No	Yes
Psychiatric		
Excessive worries	O	O
Anxiety	O	O
Easily losing temper	O	O
Depression	O	O
Agitation	O	O
Difficulty falling asleep	O	O
Difficulty staying asleep	O	O
Endocrine		
Excessive thirst	O	O
Hematologic/Lymphatic		
Swollen glands	O	O
Tender glands	O	O
Anemia	O	O
Bleeding tendency	O	O
Transfusion	O	O
If yes, when? / /		
Allergic/Immunologic		
Frequent sneezing	O	O
Increased susceptibility to infection	O	O
Date of last chest x-ray: / /		