PATIENT NAME:

SYSTEM REVIEW

CONSTITUTIONAL SYMPTOMS		
Good general health lately	YES	NO
Recent weight change	YES	NO
Fever	YES	NO
Fatigue	YES	NO
Headaches	YES	NO

EYES		
Eye disease or injury	YES	NO
Wear glasses or contacts	YES	NO
Blurred or double vision	YES	NO
Glaucoma	YES	NO

EARS/NOSE/MOUTH/THROAT		
Hearing loss or ringing	YES	NO
Earaches or drainage	YES	NO
Chronic sinus problem or rhinitis	YES	NO
Nose bleeds	YES	NO
Mouth sores	YES	NO
Bleeding gums	YES	NO
Bad breath or bad taste	YES	NO
Sore throat or voice change	YES	NO
Swollen glands in neck	YES	NO

CARDIVASCULAR		
Heart trouble	YES	NO
Chest pain or angina pectoris	YES	NO
Palpitation	YES	NO
Shortness of breath with walking or lying flat	YES	NO
Swelling of feet, ankles or hands	YES	NO

RESPIRATORY		
Chronic or frequent coughs	YES	NO
Spitting up blood	YES	NO
Shortness of breath	YES	NO
Asthma or wheezing	YES	NO

GASTROINTESTINAL		
Loss of appetite	YES	NO
Chang in bowl movements	YES	NO
Nausea or vomiting	YES	NO
Frequent diarrhea	YES	NO
Painful bowel movements or constipation	YES	NO
Rectal bleeding or blood in stool	YES	NO
Abdominal pain or heartburn	YES	NO
Peptic ulcer (stomach or duodenal)	YES	NO

PSYCHIATRIC		
Memory loss or confusion	YES	NO
Nervousness	YES	NO
Depression	YES	NO

MUCULOSKELETETAL		
Joint pain	YES	NO
Joint stiffness or swelling	YES	NO
Weakness of muscles or joints	YES	NO
Muscle pain or cramps	YES	NO
Back pain	YES	NO
Cold extremities	YES	NO
Difficulty walking	YES	NO

INTEGUMENTARY (SKIN, Breast)		
Rash or itching	YES	NO
Change in skin color	YES	NO
Change in hair or nails	YES	NO
Varicose veins	YES	NO
Breast pain	YES	NO
Breast lump	YES	NO
Breast discharge	YES	NO

ENDOCRINE		
Glandular or hormone problem	YES	NO
Thyroid disease	YES	NO
Diabetes	YES	NO
Excessive thirst or urination	YES	NO
Heat or cold intolerance	YES	NO
Skin becoming dryer	YES	NO
Change in hat or glove size	YES	NO

HEMATOLOGICAL/LYMPHATIC		
Slow to heal after cuts	YES	NO
Bleeding or bruising tendency	YES	NO
Anemia	YES	NO
Phlebitis	YES	NO
Past transfusions	YES	NO
Enlarged glands	YES	NO

GENITOURANARY		
Frequent urination	YES	NO
Burning or painful urination	YES	NO
Blood in urine	YES	NO
Change in force/strain when urinating	YES	NO
Incontinence or dribbling	YES	NO
Kidney stones	YES	NO
Sexual difficulty	YES	NO
Male-testicle pain	YES	NO
Female-pain with periods	YES	NO
Female-irregular periods	YES	NO
Female-vaginal discharge	YES	NO
Female-# of pregnancies	YES	NO
Female-# of miscarriages	YES	NO
Female-date of last pap smear	YES	NO