SYSTEM REVIEW

PATIENT NAME____
DATE____

***CONSTITUTIONAL SYMPTOMS**

Good general health	No	Yes
Recent weight change	No	Yes

***EYES**

Eye disease or injury	No	Yes
Blurred vision	No	Yes
Glaucoma	No	Yes

***EARS/NOSE/THROAT**

Hearing loss or ringing	No	Yes
Earaches or drainage	No	Yes
Chronic sinus problems	No	Yes
Nose bleeds	No	Yes
Bleeding gums	No	Yes
Sore throat/voice change	No	Yes

***CARDIOVASCULAR**

Heart disease	No	Yes
Chest pain or angina	No	Yes
Palpitations	No	Yes
Swelling of feet,ankles,hands	No	Yes

***RESPIRATORY**

Chronic/frequent coughs	No	Yes
Spitting up of blood	No	Yes
Shortness of breath	No	Yes
Smoking (quantity_______)	No	Yes

***GASTROINTESTINAL**

Loss of appetite	No	Yes
Change in bowel movements	No	Yes
Nausea or vomiting	No	Yes
Frequent diarrhea	No	Yes
Constipation	No	Yes
Rectal bleeding/blood in stool	No	Yes
Abdominal pain	No	Yes
Heartburn/Ulcers	No	Yes

***GENITOURINARY**

Frequent urination	No	Yes
Burning/painful urination	No	Yes
Blood in urine	No	Yes
Incontinence or dribbling	No	Yes
Kidney stones	No	Yes
Sexual difficulty	No	Yes
Painful periods	No	Yes
Irregular periods	No	Yes
Vaginal discharge/odor	No	Yes

# of pregnancies________ # of miscarriages______

Date of last pap smear ________________________

***MUSCULOSKELETAL**

Joint pain	No	Yes
Joint stiffness or swelling	No	Yes
Weakness of muscles/joints	No	Yes
Back pain	No	Yes

***BREAST**

Breast pain	No	Yes
Breast lump	No	Yes
Breast discharge	No	Yes
Change in breast appearance	No	Yes

***NEUROLOGICAL**

Frequent or recurring headaches	No	Yes
Lightheaded or dizzy	No	Yes
Numbness or tingling sensations	No	Yes
Head injury	No	Yes
Memory loss or confusion	No	Yes

***PSYCHIATRIC**

Nervousness	No	Yes
Depression	No	Yes
Insomnia	No	Yes
Alcohol Consumption (quantity______)	No	Yes
Drugs Usage _____________________	No	Yes

***ENDOCRINE**

Thyroid disease	No	Yes
Diabetes	No	Yes
Excessive thirst or urination	No	Yes
Heat or cold intolerance	No	Yes
Dry skin	No	Yes

***HEMATOLOGIC/LYMPHATIC**

Slow to heal after cuts	No	Yes
Bleeding or bruising tendency	No	Yes
Anemia	No	Yes
Phlebitis	No	Yes
Past transfusion	No	Yes

***ALLERGIC/IMMUNOLOGIC**

History of skin reaction or other adverse reaction to:

Penicillin or other antibiotics	No	Yes
Other_______________________		
Novocaine or other anesthetics	No	Yes
Other_______________________		
Aspirin or other pain medication	No	Yes
Other_______________________		
Iodine or other antiseptics	No	Yes
Other_______________________		
Flu/pneumonia vaccine	No	Yes

Other allergies________________________

Date of last Tetanus Shot ______________________

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PHYSICIAN'S SIGNATURE

____
DATE

11/06