

SYSTEM REVIEW***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 _____

PATIENT NAME _____

DATE _____

***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 _____

PHYSICIAN'S SIGNATURE _____

DATE _____