# SYSTEMS REVIEW

Patient Name: _____ Date: _____

**CONSTITUTIONAL**

☐ Recent weight gain: ____lbs
☐ Recent weight loss: ____lbs
☐ Fatigue
☐ Night Sweats
☐ Change in appetite

**EYES**

☐ Pain
☐ Redness
☐ Loss of vision
☐ Double blurred vision
☐ Dryness
☐ Feels like something in eye
☐ Itching eyes

**Ears-Nose-Mouth-Throat**

☐ Ringing in ears
☐ Loss of hearing
☐ Nosebleeds
☐ Loss of smell
☐ Tongue or jaw pain with chewing
☐ Bleeding gums
☐ Sores in mouth
☐ Dryness of mouth
☐ Frequent sore throats
☐ Hoarseness
☐ Difficulty in swallowing

**CARDIOVASCULAR**

☐ Pain in chest
☐ Irregular heartbeat
☐ Sudden change in heart beat
☐ High blood pressure
☐ Heart murmurs
☐ Swollen legs or feet
☐ Color changes of hands/fee in the cold

**RESPIRATORY**

☐ Shortness of breath
☐ Difficulty in breathing at night
☐ Cough
☐ Coughing up blood
☐ Wheezing

**MUSCULOSKELETAL**

Morning stiffness: __Yes __No
Lasting how long: _____
☐ Joint pain
☐ Muscle weakness
☐ Muscle tenderness
☐ Joint swelling

_____
_____

**GASTROINTESTINAL**

☐ Nausea
☐ Vomiting
☐ Stomach pain relieved by food or milk
☐ Jaundice
☐ Increasing constipation
☐ Persistent diarrhea
☐ Blood in stools
☐ Black stools
☐ Heartburn

**GENITOURINARY**

☐ Difficult urination
☐ Pain or burning on urination
☐ Blood in urine
☐ Cloudy, "smoky" urine
☐ Pus in urine
☐ Discharge from penis/vagina
☐ Getting up at night to pass urine
☐ Rash/ulcers
☐ Sexual difficulties

**INTEGUMENTARY (SKIN &/OR BREAST)**

☐ Easy bruising
☐ Redness
☐ Rash
☐ Hives
☐ Sun sensitive (sun allergy)
☐ Tightness
☐ Nodules/bump
☐ Hair loss
☐ Changes to nails

**FOR WOMEN ONLY**

Age when period began:____
Period regular? ___Yes ___No
How many days apart? _____
Date of last period: ___/___/____
Date of last pap: ___/___/____
Bleeding after menopause? __Yes __No
# of pregnancies: ____
# of miscarriages: ____

**NEUROLOGICAL SYSTEM**

☐ Headaches
☐ Dizziness
☐ Fainting
☐ Muscle spasm
☐ Loss of consciousness
☐ Numbness or tingling of hands or feet
☐ Memory loss

**PSYCHIATRIC**

☐ Excessive worries
☐ Anxiety
☐ Depression
☐ Difficulty falling asleep
☐ Difficulty staying asleep

**ENDOCRINE**

☐ Excessive thirst

**HEMATOLOGIC/LYMPHATIC**

☐ Swollen glands
☐ Tender glands
☐ Bleeding tendency
☐ Transfusion/when: ___/___/____

**SOCIAL HISTORY**

Do you drink caffeinated beverages? ___Yes ___No
If yes, # cups/glasses per day: ____
Do you smoke? ___Yes ___No
If past smoker, how long ago? _____
Do you drink alcohol? ___Yes ___No
Average # glasses per week: ____
Has anyone ever told you to cut down on your drinking? ___Yes ___No
Do you use drugs for reasons that are not medical?
___Yes ___No
if yes, please list: _____
_____
Do you exercise regularly? ___Yes ___No
If yes, what type of exercise?
_____
Amount per week: _____
How many hours of sleep do you get at night? ____
Do you get enough sleep at night?
___Yes ___No
Do you wake up feeling rested?
___Yes ___No

Physician Initials: _____