

Patient: \_\_\_\_\_ Date: \_\_\_\_\_ Acct: \_\_\_\_\_

## SYSTEMS REVIEW

Please indicate with a (C) conditions you have now or with a (P) the conditions that you have had in the past. If neither applies, mark NA. Please do not leave blanks.

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> High Blood Pressure  | <input type="checkbox"/> Difficulty Breathing    | <input type="checkbox"/> Hands/Feet Cold   |
| <input type="checkbox"/> Dizziness/Fainting   | <input type="checkbox"/> Heart Problems          | <input type="checkbox"/> Hand Tremors      |
| <input type="checkbox"/> Insomnia             | <input type="checkbox"/> Loss of Bladder Control | <input type="checkbox"/> Loss of Memory    |
| <input type="checkbox"/> Low Resistance       | <input type="checkbox"/> Constipation            | <input type="checkbox"/> Nervousness       |
| <input type="checkbox"/> Tension              | <input type="checkbox"/> Diarrhea                | <input type="checkbox"/> Sweaty Palms      |
| <input type="checkbox"/> Confusion            | <input type="checkbox"/> Digestion Problems      | <input type="checkbox"/> Speech Difficulty |
| <input type="checkbox"/> Fatigue              | <input type="checkbox"/> Nausea                  | <input type="checkbox"/> Anxiety           |
| <input type="checkbox"/> Ulcers               | <input type="checkbox"/> Female Problems         | <input type="checkbox"/> Depression        |
| <input type="checkbox"/> Eye/Vision Problems  | <input type="checkbox"/> Prostate Problems       | <input type="checkbox"/> Irritability      |
| <input type="checkbox"/> Ear/Hearing Problems | <input type="checkbox"/> Diabetes                |  |

Please identify all facilities/providers you have seen for these conditions and those you are currently seeing, if any, for your presenting problem(s):

Doctor's Name/Facility	Surgery/Treatment	Procedure Received	Date(s) of Procedure

### For Doctor's Use Only

Dr. Reviewed	Systems	Symptoms	Dr. Comments
	General	Weight changes, fatigue, anorexia, weakness, fever, changes in activity	
	Skin	Rashes, eruptions, changes in warts, moles, or pigmentation, bruising, itching, hair loss, nail changes	
	Head	Trauma, headaches, dizziness, light headed	
	Eyes	Changes in acuity in vision, use of corrective lenses, blurred vision, increased tearing, redness, discharge, pain	
	Nose	Rhinorrhea, epinitis, allergies, airway obstruction	
	Mouth & Throat	Ulcers, tooth pain/extraction, TMJ pain, gum bleeding, soreness, swelling, enlarged glands, sore throat, strep	
	Neck	Stiffness, lumps/swelling/masses, pain	
	Lungs	Cough (productive/non productive), hemoptysis, dyspnea, pain with respiration, wheezing, night sweats	
	Cardiac	Palpitation, chest pain, orthopnea, paroxysmal nocturnal dyspnea, ankle swelling, syncope	
	Vascular	Raynaud's phenomenon, intermittent claudication, hypertension, rheumatic fever	
	Breasts	Self-examination frequency/results, pain, nipple discharge, lumps/masses, skin, dimpling	
	Gastrointestinal	Usual diet, regurgitation, dyspepsia, nausea, vomiting, belching, abdominal pain, cramps, hematemesis	
		Stool color changes, diarrhea, constipation, change in bowel habits, jaundice, abdominal swelling, BM frequency	
	Genitourinary	Polyuria, dysuria, urgency, stress incontinence, urine color changes, hematuria, STD, nocturia, hernia, scrotal mass	
	Endocrine	Polydispia, polyphagia, temp. intolerance, tremors, goiter, alopecia, dysmenorrhea, PMS, menstrual hx, pregnancy hx	
	Hemtopoietic	Anemia, abdominal bleeding, lymph node enlargement/pain	
	Musculoskeletal	Bone/joint pain, swelling, joint deformity, trauma, restricted range of motion, weakness, atrophy	
	Neurological	Cranial nerve deficits, seizures, LOC, tremors, stasis, loss of balance, numbness, paresthesia	
	Psychological	Mood swings, depression, anxiety, phobias	

Doctor's Initials \_\_\_\_\_