

## Systems Review

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

Indicate by checking "yes" or "no" to any symptoms you have had in **recent** months. **Circle** the symptoms you have had when multiple symptoms are listed.

	No	Yes	Medical Team use only
1. Skin rash, sore, excessive bruising or change of a mole?	___	___	_____
2. Excessive thirst or urination?	___	___	_____
3. Change in sexual drive or performance?	___	___	_____
4. <u>Significant headaches, slurred speech, difficulty moving/numbness in an arm or leg?</u>	___	___	_____
5. Eye problems such as double or blurred vision, cataracts or glaucoma?	___	___	_____
6. Diminished hearing, dizziness, hoarseness or sinus problem?	___	___	_____
7. Nosebleeds, ringing in the ears?	___	___	_____
8. <u>Cough, shortness of breath, wheezing or asthma?</u>	___	___	_____
9. Coughing up sputum or blood?	___	___	_____
10. Exposed to anyone with tuberculosis?	___	___	_____
11. "Blacked out", lost consciousness or had a seizure?	___	___	_____
12. <u>Chest pain/pressure, rapid or irregular heart beats, heart valve problems?</u>	___	___	_____
13. Awakening at night short of breath?	___	___	_____
14. Abnormal swelling in the legs or feet?	___	___	_____
15. Pain in the calves of your legs when you walk?	___	___	_____
16. <u>Difficulty swallowing, heartburn, nausea, vomiting, bloating or stomach trouble?</u>	___	___	_____
17. Significant constipation/diarrhea; blood or changes in bowel movements?	___	___	_____
18. Past history of yellow jaundice or colon polyps?	___	___	_____
19. Difficulty starting urination, emptying bladder or involuntarily losing urine?	___	___	_____
20. <u>Burning, pain or blood when urinating?</u>	___	___	_____
21. Pain, stiffness or swelling in your back, joints or muscles?	___	___	_____
22. Hot flashes or night sweats?	___	___	_____
23. Enlarged glands (lymph nodes)?	___	___	_____
24. <u>Do you feel you are at risk for HIV or AIDS?</u>	___	___	_____
25. History of anemia, elevated cholesterol or blood sugar?	___	___	_____
26. Experiencing a stressful situation or depressed mood?	___	___	_____
27. Weight gain/loss of 10 pounds during the last 6 months?	___	___	_____
28. <u>Problems falling asleep, sleep apnea or disruptive snoring?</u>	___	___	_____
29. Abnormal nipple discharge or breast lump?	___	___	_____
30. Have you felt a need to cut down on alcohol consumption?	___	___	_____
31. Do relatives/friends worry or complain about your alcohol consumption?	___	___	_____
32. <u>Have you been physically, sexually or emotionally abused?</u>	___	___	_____
<b><u>For Female patients only</u></b>			
33. Have you ever had an abnormal Pap smear?	___	___	_____
34. Have you experienced menopause or had a hysterectomy?	___	___	_____
If "no": Are you concerned about your periods?	___	___	_____
Might you be pregnant at this time?	___	___	_____
Date of onset of your last period _____			
35. Number of: Pregnancies _____ Live births _____ Miscarriages/Abortions _____	___	___	_____