

SYSTEM REVIEW FORM

Name: _____

Today's Date: _____

1. GENERAL

- _____ Weakness
- _____ Weight loss
- _____ What would you like to weigh
- _____ Fever/Chills
- _____ Night sweats
- _____ Appetite changes
- _____ Sleeping Problems
- _____ Lack of exercise
- _____ Swelling Nodes
- _____ Heat or Cold intolerance

2. SKIN

- _____ Rash
- _____ Moles
- _____ Skin Problems (ex. Acne)
- _____ Hair loss

3. HEAD/NECK/ENT

- _____ Headaches/Neck Pain
- _____ Dizziness
- _____ Last eye exam
- _____ Blurred vision, double vision, halo
- _____ Poor vision
- _____ Hearing problems
- _____ Ear aches, ringing, buzzing, clicking
- _____ Nose bleeds/sneezing problems
- _____ Congested nose/sinus
- _____ Frequent colds
- _____ Hoarseness, sore throat
- _____ Gums, teeth problems
- _____ Tongue, taste problems

4. PULMONARY-CARDIOVASCULAR

- _____ Chest pain/heaviness
- _____ Shortness of breathe
- _____ Dyspnea, Orthopnea
- _____ Cough/Sputum
- _____ Wheeze
- _____ Coughing up blood
- _____ Palpitations
- _____ Edema
- _____ Cramps when walking
- _____ Cramps at night

5. PREVIOUS IMMUNIZATIONS

- _____ Last Tuberculin skin test
- _____ Have you ever reacted positive
- _____ Date of last tetanus shot
- _____ Flu Shot
- _____ Pneumovax
- _____ Hepatitis B series

6. GASTRO-INTESTINAL

- _____ Difficulty or painful swallowing
- _____ Food Sticking
- _____ Nausea, Vomiting
- _____ Food intolerance
- _____ Heart Burn
- _____ Pain (abdominal or rectum)
- _____ Vomiting blood
- _____ Diarrhea/constipation
- _____ Blood in stool/Clay like stools
- _____ Belching

7. URINARY/MALE GENITAL

- _____ Frequency/Urination at night
- _____ Burning
- _____ Urgency
- _____ Dribbling, hesitation, split stream
- _____ Blood in Urine
- _____ Incontinence
- _____ Prostate, scrotal problems

8. FEMALE/GENITAL/URINARY

- _____ Pregnancies
- _____ Premature/abortions/living children
- _____ LMP _____ Last pap
- _____ Menarche
- _____ Menopausal
- _____ Frequency
- _____ Duration
- _____ Am't Flow (pads/tampons/day)
- _____ Cramps with periods
- _____ Postmenopausal bleed
- _____ Vaginal discharge, itching
- _____ Contraception
- _____ Mammogram
- _____ Frequency/Urgency
- _____ Burning
- _____ Blood in urine

9. NEUROLOGIC/MUSCLO SKELETAL

- _____ Convulsions
- _____ Numbness
- _____ Tremor/shaking
- _____ Joint or back pain
- _____ Joint swelling

10. PSYCHOLOGICAL

- _____ Excess tension home/work
- _____ Work/Family problems
- _____ Sexual difficulties
- _____ Depression/nervous
- _____ Suicidal thoughts

Weight: _____

Height: _____

Temp: _____

Pulse: _____

Resp. Rate: _____

Blood Pressure: _____

Medications: _____