

SYSTEM REVIEW

GENERAL

Do you eat a well balanced diet? NO YES
 Approx. weight now _____ 1 yr ago _____
 Maximum weight _____
 Exercise? Frequently / wk _____
 Activities _____
 Any sexual concerns? NO YES
 Year Last Complete Physical? _____
 Headaches NO YES
 Glasses/contacts NO YES
 Double Vision NO YES
 Eye disease or injury NO YES
 Last year checked for glaucoma _____
 Itching eyes or nose/hay fever NO YES
 Septal deviation/ polyps (circle) NO YES
 Nosebleeds NO YES
 Sinus Trouble NO YES
 Ear Disease NO YES
 Impaired Hearing NO YES
 Ringing in the ears NO YES
 Hoarseness NO YES

NECK

Stiffness NO YES
 Enlarged glands NO YES
 Injury NO YES

RESPIRATORY

Coughing up blood NO YES
 Chronic cough(incl. Smoker's cough) NO YES
 Wheezing NO YES
 Shortness of Breath NO YES
 History of allergies/asthma NO YES
 Skin test for tuberculosis NO YES
 If yes, year and test results _____
 Year of last chest X-Ray _____

CARDIOVASCULAR

Chest pain NO YES
 Shortness of breath when lying flat NO YES
 Pain in legs on walking, relieved by rest NO YES
 Varicose Veins NO YES
 Ankles often badly swollen NO YES
 Heart Murmur NO YES
 Rapid, hard or skipped heart beats NO YES
 Year of last EKG? _____
 Have you had a stress treadmill? Year _____ NO YES
 Have you had a echocardiogram? Year _____ NO YES

GASTROINTESTINAL

Change in appetite NO YES
 Heartburn, burping or indigestion NO YES
 Sour taste in throat or mouth NO YES
 Intolerance to spicy foods, coffee or alcohol NO YES
 Ever vomited blood NO YES
 Food sticks in your throat NO YES
 Gallbladder trouble/intol. to greasy foods NO YES
 Intolerance to milk products NO YES
 Pancreatitis NO YES
 Vomit often NO YES
 Crampy abdominal pain NO YES
 Chronic constipation NO YES
 Frequent diarrhea NO YES
 Change in bowel habits NO YES
 Bloody or black bowel movements NO YES
 Hemorrhoids or piles NO YES

GENITOURINARY

Loss of urine when cough or sneeze NO YES
 Kidney or bladder infection (circle) NO YES
 Burning or frequent urination (circle) NO YES
 Feeling must go immediately? NO YES
 Do you have to get up at night to urinate? # _____ NO YES
 Blood in urine NO YES
 Kidney Stones NO YES
 Swelling of hands and feet NO YES
 Difficulty starting urination NO YES
 Decrease in strength of stream NO YES
 Penile Discharge NO YES
 Date of last prostate exam? _____

MUSCULOSKELETAL/ NEUROLOGIC

Joint Pain NO YES
 Back Pain NO YES
 Numbness / weakness of extremity NO YES
 Limited use of extremity NO YES
 Loss of balance NO YES
 Dizziness NO YES
 Difficulty walking NO YES

SKIN

Skin Disorders (list) NO YES

BEHAVIORAL

Loss of memory NO YES
 Lack of motivation NO YES
 Fatigue NO YES
 Anxious or nervous NO YES
 Trouble sleeping NO YES
 Mood swings NO YES
 Have you ever been under psychiatric care? NO YES

HEMATOLOGIC

Excessive bleeding or abnormal bruising NO YES
 Spleen removed? NO YES

ENDOCRINE

Crave large amounts of fluids NO YES
 Frequent urination NO YES
 Intolerance to slightly warm/cool rooms NO YES
 Night Sweats NO YES
 Hot flashes NO YES
 Recent fracture of extremity NO YES

GYNECOLOGICAL (women only)

Age when periods started _____ years old
 Frequency: every _____ days; Last period _____
 Are they abnormal or irregular? NO YES
 Menopausal _____ Age? _____ NO YES
 Number of pregnancies _____ C- Sections _____
 Term deliveries _____ Premature _____
 Miscarriages _____ Abortions _____
 Pelvic inflammatory disease NO YES
 Pain with intercourse NO YES
 Date of last PAP smear? _____ Normal? NO YES
 Breast masses, lumps, cyst (circle) NO YES
 Nipple discharge NO YES
 Family History of breast cancer NO YES
 Date of last mammogram _____ NO YES
 Did someone other than the patient help fill this out? NO YES

Patient Signature: _____

Reviewing Physician: _____