





**CIRCLE NO OR YES FOR THOSE THAT APPLY**

**SYSTEMIC REVIEW:** Do you have any of the following?

General: Maximum weight \_\_\_\_\_ Minimum weight \_\_\_\_\_  
 Recent weight change? ..... No Yes  
 Have you been in good general health most of your life? .... No Yes  
 Have you recently had?  
 Weakness     Fever     Chills     Night Sweats  
 Fainting     Problems Sleeping

**Skin:**  
 Skin Disease ..... No Yes  
 Jaundice ..... No Yes  
 Hives, eczema or rash ..... No Yes

**Head-Eyes-Ears-Nose-Throat (cont'd):**  
 Dry eyes or mouth ..... No Yes  
 Bleeding Gums - Frequent or Constant ..... No Yes  
 Blurred Vision ..... No Yes  
 Date of Last Eye Exam \_\_\_\_\_  
 Sneezing or runny nose ..... No Yes  
 Nosebleeds - Frequent ..... No Yes  
 Chronic sinus trouble ..... No Yes  
 Ear disease ..... No Yes  
 Impaired hearing ..... No Yes  
 Dizziness or sensation of room spinning ..... No Yes  
 Frequent or severe headaches ..... No Yes

**Respiratory:**  
 Asthma or Wheezing ..... No Yes  
 Difficulty breathing ..... No Yes  
 Any trouble with lungs ..... No Yes  
 Pleurisy or Pneumonia ..... No Yes  
 Cough up Blood (ever) ..... No Yes

**Cardiovascular:**  
 Chest pain, pressure, or tightness ..... No Yes  
 Shortness of breath with walking or lying down ..... No Yes  
 Difficulty walking two blocks ..... No Yes  
 Palpitations ..... No Yes  
 Swelling of hands, feet or ankles ..... No Yes  
 Awakening in the nights smothering ..... No Yes  
 Heart murmur ..... No Yes

**Gastrointestinal:**  
 Vomiting blood or food ..... No Yes  
 Gallbladder disease ..... No Yes  
 Change in appetite ..... No Yes  
 Hepatitis/Jaundice ..... No Yes  
 Painful bowel movements ..... No Yes  
 Bleeding with bowel movements ..... No Yes  
 Black stools ..... No Yes  
 Hemorrhoids or piles ..... No Yes  
 Recent change in bowel habits ..... No Yes  
 Frequent diarrhea ..... No Yes  
 Heartburn or indigestion ..... No Yes  
 Cramping or pain in the abdomen ..... No Yes  
 Does food stick in throat ..... No Yes

**Endocrine:**  
 Hormone therapy ..... No Yes  
 Any change in hat or glove size ..... No Yes  
 Any change in hair growth ..... No Yes  
 Have you become colder than before -  
 or skin become dryer ..... No Yes

**Neck:**  
 Stiffness ..... No Yes  
 Enlarged glands ..... No Yes

**Genitourinary:**  
 Loss of urine ..... No Yes  
 Blood in urine ..... No Yes  
 Frequent urination ..... No Yes  
 Burning or painful ..... No Yes  
 Night time urinating ..... No Yes  
 Kidney trouble ..... No Yes  
 Problem stopping/starting flow of urine ..... No Yes  
 Testicular mass ..... No Yes  
 Testicular pain ..... No Yes  
 Prostate problem ..... No Yes  
 Sexual Dysfunction ..... No Yes  
 STD / AIDS Risk ..... No Yes

**Gynecological:**  
 First day of last period \_\_\_\_\_  
 Age periods started \_\_\_\_\_  
 How long do periods last? \_\_\_\_\_ Days  
 Frequency of periods every \_\_\_\_\_ Days  
 Pain with periods ..... No Yes  
 Number of pregnancies \_\_\_\_\_  
 Number of miscarriages \_\_\_\_\_  
 Date of last cancer smear and results \_\_\_\_\_  
 Breast Lump ..... No Yes  
 Abnormal Vaginal Discharge ..... No Yes  
 Breast Discharge ..... No Yes  
 Pain with Intercourse ..... No Yes  
 Skin change of Breast ..... No Yes  
 Nipple retraction ..... No Yes

**Locomotor-Musculoskeletal:**  
 Stiffness or pain in joints (check all that apply)  
 Finger  Hands  Wrist  Elbows  Shoulders  Neck  Back  
 Hip  Knee  Toes  Foot  Temporomandibular Joint  
 Weakness of muscles or joints ..... No Yes  
 Any difficulty in walking ..... No Yes  
 Any pain in calves or buttocks on walking  
 relieved by rest ..... No Yes

**Neuro-Psychiatric:**  
 Transient blindness  Tremor  Numbness in fingers  Weakness  
 Have you ever had counselling for your mental health? .. No Yes  
 Have you ever been advised to see a psychiatrist? ..... No Yes  
 Do you ever have, or have had, fainting spells? ..... No Yes  
 Convulsions ..... No Yes  
 Paralysis ..... No Yes  
 Problem with coordination ..... No Yes  
 Domestic violence ..... No Yes  
 Depression Symptoms (difficulty sleeping, loss of appetite  
 loss of interest in activities, feelings of hopelessness) .... No Yes

**Hematologic:**  
 Are you slow to heal after cuts? ..... No Yes  
 Anemia ..... No Yes  
 Phlebitis or Blood Clots in veins ..... No Yes  
 Have you had difficulty with bleeding excessively  
 after tooth extraction or surgery? ..... No Yes  
 Have you had abnormal bruising or bleeding? ..... No Yes

Source of information, if other than patient: \_\_\_\_\_

Signature of person acquiring this information: \_\_\_\_\_

Provider

Date

Signature of Patient