



Patient Name:

SYSTEMS REVIEW

Beside each item, please check Y (Yes), N (No), or P (Past). Please write any information required in the space provided including relevant dates and durations of specific conditions and/or symptoms.

SKIN

Rashes	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	
Eczema	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	
Hives	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	
Acne or boils	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	
Itching	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	
Colour change	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	
Lumps	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	
Dryness	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	
Moistness	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	
Nail changes	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	
Changes in mole(s)	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	
Skin cancer	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	
Night sweats	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	
Other		

HEAD

Headache	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	
Head injury	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	
Other		

EYES

Impaired vision	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	
Eye pain	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	
Tearing	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	
Dryness	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	
Double vision	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	
Glaucoma	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	
Cataracts	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	
Blurring	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	
Bothered by sun	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	
Itching	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	
Redness	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	
Discharge	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	



Patient Name:

Blind spot	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	
Other		
EARS		
Impaired hearing	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	
Earache	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	
Dizziness	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	
Discharge	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	
Infections	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	
Other		
NOSE AND SINUSES		
Frequent colds	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	
Nose bleeds	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	
Stiffness	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	
Hayfever	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	
Sinus problems	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	
Other		
MOUTH AND THROAT		
Frequent sore throat	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	
Sore tongue or mouth	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	
Gum problems	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	
Hoarseness	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	
Dental cavities	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	
Loss of taste	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	
Sores in and around the mouth	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	
Other		
NECK		
Lumps	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	
Swollen glands	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	
Goiter	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	
Pain or stiffness	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	
Other		



Patient Name:

RESPIRATORY		
Cough	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	
Sputum/phlegm	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	
Wheezing	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	
Asthma	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	
Bronchitis	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	
Pneumonia	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	
Emphysema	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	
Difficulty breathing	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	
Pain on breathing	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	
Shortness of breath	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	
Tuberculosis	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	
Last tuberculin test		
Last chest xray		
Other		
CARDIOVASCULAR		
Heart disease	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	
Angina	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	
High blood pressure	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	
Murmurs	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	
Rheumatic fever	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	
Chest pain	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	
Swelling in ankles	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	
Palpitations/fluttering	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	
Cyanosis	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	
Other		
Past ECG		
Other heart tests		
BREAST		
Lumps	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	
Pain or tenderness	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	
Nipple discharge	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	
Do you do self-breast exams?		



Patient Name:

Gastrointestinal		
Trouble swallowing	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	
Heartburn	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	
Change in thirst	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	
Change in appetite	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	
Nausea	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	
Vomiting	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	
Vomiting blood	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	
Blood in stool	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	
Belching or passing gas	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	
Liver disease	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	
Gallbladder disease	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	
Jaundice (yellow skin)	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	
Ulcer	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	
Indigestion	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	
Diarrhea	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	
Rectal bleeding	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	
Hemorrhoids	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	
Black tarry stool	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	
Light grey stool	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	
Hernias	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	
Bowel movements (how often?)		
Is this a change?		
Other		
URINARY		
Pain on urination	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	
Increased frequency	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	
Frequency at night	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	
Inability to hold urine	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	
Frequent urinary infections	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	
Kidney stones	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	
Blood in urine	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	
Urgency	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	
Hesitancy	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	



Patient Name:

Other		
MUSCULOSKELETAL		
Joint pain or stiffness	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	
Arthritis	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	
Broken bones	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	
Muscle spasms or cramps	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	
Weakness	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	
Joint swelling	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	
Backache	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	
Other		
PERIPHERAL VASCULAR		
Deep leg pain	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	
Cold hands and feet	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	
Varicose veins	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	
Thrombophlebitis	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	
Leg cramps	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	
Extremity numbness	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	
Extremity swelling	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	
Extremity ulcers	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	
Other		
NEUROLOGICAL		
Dizziness	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	
Fainting	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	
Seizures/convulsions	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	
Paralysis	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	
Muscle weakness	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	
Numbness or tingling	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	
Loss of memory	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	
Involuntary movement	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	
Loss of balance	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	
Speech problems	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	
Other		
ENDOCRINE		
Excessive thirst	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	



Patient Name:

Excessive urination	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	
Excessive sweating	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	
Excessive hair growth	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	
Other		
BLOOD AND LYMPHATICS		
Anemia	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	
Easy bleeding or bruising	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	
Lymph node swelling	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	
Other		
EMOTIONAL		
Depression	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	
Mania	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	
Mood swings	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	
Anxiety and nervousness	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	
Phobias	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	
Insomnia	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	
Other		
HOBBIES AND HABITS		
Do you eat three meals a day?	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	
Do you sleep well?	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	
Do you average 8 hours sleep a night?	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	
Do you enjoy your work?	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	
Do you watch television?	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	
If yes, how many hours do you watch?		
Do you take vacations?	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	
What are your hobbies?		
FEMALE		
Age at onset of menstruation:		
Date of last menstruation:		
Period every ____ days		
Heavy periods, irregularity, spotting, pain, or discharge?	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	
Number of pregnancies ____	Number of live births ____	



Patient Name:

Are you pregnant or breastfeeding?	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	
Have you had a D&C, hysterectomy, or Cesarean?	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	
Any urinary tract, bladder, or kidney infections within the last year?	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	
Any blood in your urine?	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	
Any problems with control of urination?	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	
Any hot flashes or sweating at night?	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	
Experienced any recent breast tenderness, lumps, or nipple discharge?	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	
Date of last pap?		
MALE		
Do you usually get up to urinate during the night?	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	
If yes, # of times _____	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	
Do you feel pain or burning with urination?	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	
Any blood in your urine?	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	
Do you feel burning discharge from penis?	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	
Has the force of your urination decreased?	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	
Have you had any kidney, bladder, or prostate infections within the last 12 months?	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	
Do you have any problems emptying your bladder completely?	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	
Any difficulty with erection or ejaculation?	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	
Any testicle pain or swelling?	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	
Date of last prostate and rectal exam?		

THANK YOU FOR COMPLETING THE FORM!

IT WILL HELP ME GAIN A BETTER UNDERSTANDING FOR YOUR ENTIRE CASE.