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SYSTEMIC REVIEW FORM

Do you have any of the following?

Recent weight change?

- ○ YES
- ○ NO

Have you been in good general health most of your life?

- ○ YES
- ○ NO

Minimum weight

____

Maximum weight

____

Have you recently had? (Check all that apply)

- ☐ Weakness
- ☐ Fainting
- ☐ Fever

(Check all that apply)

- ☐ Chills
- ☐ Problems Sleeping
- ☐ Night Sweats

SKIN:

Skin Disease

- ○ YES
- ○ NO

Jaundice

- ○ YES
- ○ NO

Hives, eczema or rash

- ○ YES
- ○ NO

HEAD - EYES - EARS - NOSE - THROAT:

Dry eyes or mouth

- ○ YES
- ○ NO

Bleeding Gums - Frequent or Constent

- ○ YES
- ○ NO

Blurred Vision

- ○ YES
- ○ NO

Date of Last Eye Exam

____

Sneezing or runny nose

- ○ YES
- ○ NO

Nosebleeds - Frequent

- ○ YES
- ○ NO

Chronic sinus trouble

- ○ YES
- ○ NO

Ear disease

- ○ YES
- ○ NO

Impaired hearing

- ○ YES
- ○ NO

Dizziness or sensation of room spinning

- ○ YES
- ○ NO

Frequent or severe headaches

- ○ YES
- ○ NO

RESPIRATORY:

Asthma or Wheezing
- YES
- NO

Difficulty breathing
- YES
- NO

Any trouble with lungs
- YES
- NO

Pleurisy or Pneumonia
- YES
- NO

Cough up Blood (ever)
- YES
- NO

CARDIOVASCULAR:

Chest pain, pressure or tightness
- YES
- NO

Shortness of breath with walking or lying down
- YES
- NO

Difficulty walking two blocks
- YES
- NO

Palpitations
- YES
- NO

Swelling of hands, feet or ankles
- YES
- NO

Awakening in the nights smothering
- YES
- NO

Heart murmur
- YES
- NO

GASTROINTESTINAL:

Vomiting blood or food
- YES
- NO

Gallbladder disease
- YES
- NO

Change in appetite
- YES
- NO

Hepatitis/Jaundice
- YES
- NO

Painful bowel movements
- YES
- NO

Bleeding with bowel movements
- YES
- NO

Black stools
- YES
- NO

Hermorrhoids or piles
- YES
- NO

Recent change in bowel habits
- YES
- NO

Frequent Diarrhea
- YES
- NO

Heartburn or indigestion
- YES
- NO

Cramping or pain in the abdomen
- YES
- NO

Does food stick in throat
- YES
- NO

ENDOCRINE:

Hormone therapy
- YES
- NO

Any change in hat or glove size
- YES
- NO

Any change in hair growth
- YES
- NO

Have you become colder than before or skin become dryer
- YES
- NO

NECK:

Stiffness

- YES
- NO

Enlarged glands

- YES
- NO

GENITOURINARY:

Loss of urine

- YES
- NO

Blood in urine

- YES
- NO

Frequent urination

- YES
- NO

Burning or painful

- YES
- NO

Night time urinating

- YES
- NO

Kidney trouble

- YES
- NO

Problem stopping/starting flow of urine

- YES
- NO

Testicular pain

- YES
- NO

Prostate problem

- YES
- NO

Sexual Dysfuntion

- YES
- NO

STD / AIDS Risk

- YES
- NO

GYNECOLOGICAL:

First day of last period:

____

Age periods started:

____

How long do periods last?

____

Frequency of periods every:

____

Pain with periods

- YES
- NO

Number of pregnancies

____

Number of miscarriages

____

Date of last cancer smear and results:

____

Breast Lump

- YES
- NO

Abnormal Vaginal Discharge

- YES
- NO

Breast Discharge

- YES
- NO

Pain with Intercourse

- YES
- NO

Skin change of Breast

- YES
- NO

Nipple retraction

- YES
- NO

LOCOMOTOR - MUSCULOSKELETAL:

Stiffness or pain in joints:

(Check all that apply)

- Finger
- Hands
- Wrist
- Elbows
- Shoulders
- Neck

(Check all that apply)

- Back
- Hip
- Knee
- Toe
- Foot
- Temporomandibular Joint

Weakness of muscles or joints

- YES
- NO

Any difficulty in walking

- YES
- NO

Any pain in calves or buttocks on walking relieved by rest

- YES
- NO

NEURO - PSYCHIATRIC:

Check all that apply:

- [ ] Transient blindness
- [ ] Tremor
- [ ] Numbness in fingers
- [ ] Weakness

Have you ever had counseling for your mental health?

- ◯ YES
- ◯ NO

Have you ever been advised to see a psychiatrist?

- ◯ YES
- ◯ NO

Do you ever have, or have had, fainting spells?

- ◯ YES
- ◯ NO

Convulsions

- ◯ YES
- ◯ NO

Paralysis

- ◯ YES
- ◯ NO

Problem with coordination

- ◯ YES
- ◯ NO

Domestic violence

- ◯ YES
- ◯ NO

Depression Symptoms (difficulty sleeping, loss of appetite, loss of interest in activities, feelings of hopelessness)

- ◯ YES
- ◯ NO

HEMATOLOGIC:

Are you slow to heal after cuts?

- ◯ YES
- ◯ NO

Anemia

- ◯ YES
- ◯ NO

Phlebitis or Blood Clots in veins

- ◯ YES
- ◯ NO

Have you had abnormal bruising or bleeding?

- ◯ YES
- ◯ NO

Have you had difficulty with bleeding excessively after tooth extraction or surgery?

- ◯ YES
- ◯ NO

Source of information, if other than patient:

____

Signature of patient or person acquiring this information:

Date

____