

# SYSTEM REVIEW

Patient Name \_\_\_\_\_ Birth Date \_\_\_\_\_ Today's Date \_\_\_\_\_

## SYSTEM REVIEW – *Have you had any of the following symptoms within the past month?*

### Constitutional

Good general health lately      Yes No  
Recent weight change            Yes No  
Fever or chills                      Yes No  
Fatigue                                Yes No  
Change in appetite                Yes No  
Poor sleep                            Yes No

### Eyes

Irritation or discharge          Yes No  
Visual difficulty                    Yes No  
Wears glasses or contacts        Yes No  
Blurred or double vision         Yes No

### Ears/Nose/Mouth/Throat

Hearing loss or ringing          Yes No  
Earaches or drainage            Yes No  
Uses hearing aids                Yes No  
Nasal drainage or bleeding      Yes No  
Mouth sores /bleeding gums    Yes No  
Wear dentures                    Yes No  
Sore throat                        Yes No  
Voice change                      Yes No  
Difficulty swallowing            Yes No  
Bad breath or taste               Yes No  
Swollen glands in neck          Yes No

### Cardiovascular

Chest pain                          Yes No  
Irregular heart beat              Yes No  
Palpitations                        Yes No  
High blood pressure              Yes No  
Heart murmur                      Yes No  
Swelling feet, ankle or hands    Yes No  
Short of breath - walking        Yes No  
Short of breath - lying flat      Yes No  
Last cholesterol check          \_\_\_\_\_

### Respiratory

Asthma or wheezing              Yes No  
Short of breath                    Yes No  
Chronic or frequent cough        Yes No  
Dark or bloody sputum            Yes No  
Need extra pillows                Yes No

### Gastrointestinal

Heartburn or indigestion        Yes No  
Abdominal pain                    Yes No  
Nausea or vomiting              Yes No  
Vomiting of blood                Yes No  
Rectal bleeding                    Yes No  
Blood in stool                      Yes No  
Frequent diarrhea                Yes No  
Painful bowel movements        Yes No  
Constipation or gas              Yes No  
Lactose intolerant                Yes No  
Yellow jaundice                    Yes No

### Genitourinary

Burning or painful urination    Yes No  
Blood in urine                    Yes No  
Difficulty starting stream        Yes No  
Stream starts and stops         Yes No  
Dribbling or incontinence      Yes No  
Urinating \_\_\_\_\_times a night  
Urinary frequency /urgency    Yes No  
Bedwetting                        Yes No  
Sexual difficulty                 Yes No  
Male:  
Testicular pain                    Yes No  
Female:  
Painful periods                    Yes No  
Irregular or excessive periods  Yes No  
Vaginal discharge                Yes No  
# of Pregnancies                 \_\_\_\_\_  
# of Miscarriages                 \_\_\_\_\_  
Date last pap smear              \_\_\_\_\_

### Musculoskeletal

Joint pain                          Yes No  
Weakness of muscles or joints    Yes No  
Muscle pain or cramps            Yes No  
Difficulty walking                Yes No  
Back pain                         Yes No  
Foot or hand tingling or pain    Yes No

### Allergic/Immunologic

Sneezing or wheezing            Yes No  
Allergic reactions                Yes No

### Integumentary (Breast)

Breast pain                        Yes No  
Breast discharge                 Yes No  
Rashes                              Yes No  
Lumps or bumps                  Yes No  
Do monthly self breast exams  Yes No  
Last mammogram                 \_\_\_\_\_

### Integumentary (Skin)

Rash or itching                    Yes No  
Lumps or bumps                  Yes No  
Hair loss                          Yes No  
Open sores or scaling            Yes No  
Dryness or cracking              Yes No  
Change in skin color             Yes No  
Change in hair or nails         Yes No

### Neurological

Frequent headache                Yes No  
Recurring headache              Yes No  
Light headed or dizzy            Yes No  
Numbness or tingling            Yes No  
Convulsions or seizures        Yes No  
Memory loss or confusion      Yes No  
Fainting                            Yes No

### Psychiatric

Insomnia                          Yes No  
Anxiety or nervousness         Yes No  
Mood swings                      Yes No  
Suicidal thoughts                Yes No  
Depression                        Yes No

### Endocrine

Excessive thirst/urination      Yes No  
Heat or cold intolerance        Yes No  
Slow to heal                      Yes No  
Loss of sex drive                Yes No

### Hematological/Lymphatic

Slow to heal after cuts         Yes No  
Bleeding/bruising tendency    Yes No  
Past transfusions                Yes No  
Blood clots                        Yes No

Additional comments:

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Patient reviewed: \_\_\_\_\_ Date \_\_\_\_\_ Reviewed \_\_\_\_\_ Date \_\_\_\_\_ Reviewed \_\_\_\_\_ Date \_\_\_\_\_

Staff member reviewed: \_\_\_\_\_ Date \_\_\_\_\_ Reviewed \_\_\_\_\_ Date \_\_\_\_\_ Reviewed \_\_\_\_\_ Date \_\_\_\_\_