

## SYSTEMS REVIEW

As you review the following list, please check any of those problems which have significantly affected you.

Date of last mammogram \_\_\_\_\_ Date of last eye exam \_\_\_\_\_ Date of last chest x-ray \_\_\_\_\_

Date of last Tuberculosis Test \_\_\_\_\_ Date of last bone densitometry \_\_\_\_\_

### Constitutional

Recent weight gain  
amount \_\_\_\_\_

Recent weight loss  
amount \_\_\_\_\_

Fatigue  
Weakness  
Fever

### Eyes

Pain  
Redness  
Loss of vision  
Double or blurred vision  
Dryness  
Feels like something in eye  
Itching eyes

### Ears–Nose–Mouth–Throat

ringing in ears  
Loss of hearing  
Nosebleeds  
Loss of smell  
Dryness in nose  
Runny nose  
Sore tongue  
Bleeding gums  
Sores in mouth  
Loss of taste  
Dryness of mouth  
Frequent sore throats  
Hoarseness  
Difficulty in swallowing

### Cardiovascular

Pain in chest  
Irregular heart beat  
Sudden changes in heart beat  
High blood pressure  
Heart murmurs

### Respiratory

Shortness of breath  
Difficulty in breathing at night  
Swollen legs or feet  
Cough  
Coughing of blood  
Wheezing (asthma)

### Gastrointestinal

Nausea  
Vomiting of blood or coffee ground  
material  
Stomach pain relieved by food or milk  
Jaundice  
Increasing constipation  
Persistent diarrhea  
Blood in stools  
Black stools  
Heartburn

### Genitourinary

Difficult urination  
Pain or burning on urination  
Blood in urine  
Cloudy, "smoky" urine  
Pus in urine  
Discharge from penis/vagina  
Getting up at night to pass urine  
Vaginal dryness  
Rash/ulcers  
Sexual difficulties  
Prostate trouble

#### *For Women Only:*

Age when periods began: \_\_\_\_\_

Periods regular? Yes No

How many days apart? \_\_\_\_\_

Date of last period? \_\_\_\_\_

Date of last pap? \_\_\_\_\_

Bleeding after menopause? Yes No

Number of pregnancies? \_\_\_\_\_

Number of miscarriages? \_\_\_\_\_

### Musculoskeletal

Morning stiffness  
Lasting how long?  
\_\_\_\_\_ Minutes \_\_\_\_\_ Hours

Joint pain  
Muscle weakness  
Muscle tenderness

Joint swelling

List joints affected in the last 6 mos.

### Integumentary (skin and/or breast)

Easy bruising  
Redness  
Rash  
Hives  
Sun sensitive (sun allergy)  
Tightness  
Nodules/bumps  
Hair loss  
Color changes of hands or feet in the  
cold

### Neurological System

Headaches  
Dizziness  
Fainting  
Muscle spasm  
Loss of consciousness  
Sensitivity or pain of hands and/or feet  
Memory loss  
Night sweats

### Psychiatric

Excessive worries  
Anxiety  
Easily losing temper  
Depression  
Agitation  
Difficulty falling asleep  
Difficulty staying asleep

### Endocrine

Excessive thirst

### Hematologic/Lymphatic

Swollen glands  
Tender glands  
Anemia  
Bleeding tendency  
Transfusion/when \_\_\_\_\_

### Allergic/Immunologic

Frequent sneezing  
Increased susceptibility to infection

Patient's Name \_\_\_\_\_ Date \_\_\_\_\_ Physician Initials \_\_\_\_\_