SYSTEM REVIEW **Patient Name**_____

Have you recently experienced any of the following?

CONSTITUTIONAL	**Circle**	
Good general heath lately	No	Yes
Recent weight change	No	Yes
Fever	No	Yes
Fatigue	No	Yes
Headaches	No	Yes
EYES		
Eye disease or injury	No	Yes
Wear contact lenses or glasses	No	Yes
Blurred vision or double vision	No	Yes
EARS / NOSE / MOUTH / THROAT		
Hearing loss or ringing	No	Yes
Earaches or drainage	No	Yes
Chronic sinus problems or rhinitis	No	Yes
Nose Bleeds	No	Yes
Mouth sores	No	Yes
Bleeding gums	No	Yes
Sore throat or voice change	No	Yes
Swollen glands in neck	No	Yes
Difficulty chewing or swallowing	No	Yes
Excessive Snoring	No	Yes
CARDIOVASCULAR		
Heart trouble	No	Yes
Chest pain or angina pectoris	No	Yes
Palpitations	No	Yes
Shortness of breath with lying flat or walking	No	Yes
Swelling of feet, ankles or hands	No	Yes
RESPIRATORY		
Chronic or frequent coughs	No	Yes
Spitting up blood	No	Yes
Shortness of breath	No	Yes
Asthma or wheezing	No	Yes
GASTROINTESTINAL		
Loss of appetite	No	Yes
Change in bowel movements	No	Yes
Nausea or vomiting	No	Yes
Frequent diarrhea	No	Yes
Painful bowel movements or constipation	No	Yes
Rectal bleeding or blood in stool	No	Yes
Abdominal pain or heartburn	No	Yes
Anal discharge	No	Yes
HEMATOLOGIC / LYMPHATIC		
Slow to heal after cuts	No	Yes
Phlebitis or blood clots	No	Yes
Past transfusion	No	Yes
Enlarged glands	No	Yes

MUSCULOSKELETAL	**Circle**	
Joint Pain	No	Yes
Joint swelling	No	Yes
Weakness of muscles or joints	No	Yes
Muscle pain or cramps	No	Yes
Back pain	No	Yes
Cold extremities	No	Yes
Difficulty with walking	No	Yes
GENITOURINARY		
Frequent urination	No	Yes
Burning or painful urination	No	Yes
Blood in urine	No	Yes
Change of force of stream when urinating	No	Yes
Incontinence	No	Yes
Sexual difficulty	No	Yes
Male- testicle pain	No	Yes
Male- penile discharge	No	Yes
Female- pain with periods	No	Yes
Female- irregular periods	No	Yes
Female- vaginal discharge	No	Yes
Female- # pregnancies____# miscarriages___		
Female- Date last menstrual period-		
Female- problems with pregnancy	No	Yes
Both-Birth control use? Type_____	No	Yes
INTEGUMENTARY (skin, breast)		
Rash or itching	No	Yes
Change in skin color	No	Yes
Change in hair or nails	No	Yes
Varicose veins	No	Yes
Breast pain	No	Yes
Breast lump	No	Yes
Nipple discharge	No	Yes
NEUROLOGICAL		
Frequent or recurring headaches	No	Yes
Lightheadedness or dizziness	No	Yes
Numbness or tingling sensations	No	Yes
Tremors	No	Yes
Paralysis	No	Yes
PSYCHIATRIC / BEHAVIORAL		
Memory loss or confusion	No	Yes
Nervousness	No	Yes
Depression	No	Yes
Insomnia	No	Yes
ENDOCRINE		
Excessive thirst or urination	No	Yes
Heat or cold intolerance	No	Yes
Skin becoming drier	No	Yes

Physician Signature and date_____