SYSTEM REVIEW

Name:___________________________________ Date:____________

Please circle yes or no if you have recently experienced the following:

General:

Weight Loss ....Yes ....No
Chronic Fatigue ....Yes ....No

Allergic/Immunologic:

Medication Allergy ....Yes ....No
Food Allergy ....Yes ....No
Reaction to Radiologic Contrast ....Yes........No

Ears, nose and throat:

Hoarseness ....Yes ....No
Lumps in the neck ....Yes ....No

Endocrine: ....

Diabetes ....Yes ....No
Thyroid disease ....Yes ....No

Eyes:

Double vision ....Yes ....No
Glaucoma ....Yes ....No
Corrective lenses ....Yes ....No

Hematologic:... ....

Anemia. ....Yes ....No
Bleeding ....Yes ....No
Blood transfusion ....Yes ....No

Heart disease: ....

Angina . ...Yes ....No
Palpitations ....Yes ....No
High blood pressure ....Yes ....No
Congestive Heart Failure .. ..Yes ......No
Pacemaker ....Yes ....No

Lung disease: .. ..

Tuberculosis ....Yes ....No
Shortness of breath ....Yes ....No
Asthma. ....Yes ....No
Coughing up blood ....Yes ....No

Gastrointestinal:.......... ....

Ulcers... ....Yes ....No
Constipation ....Yes ....No
Diarrhea ....Yes ....No
Blood in the stool ....Yes ....No

Genitourinary: ....

Kidney stone ....Yes ....No
Blood in the urine ....Yes ....No
Frequent urinary tract infections ....Yes ....No

Musculoskeletal:

Fractures ....Yes ....No
Arthritis ....Yes ....No

Neurologic: ....

Stroke .... Yes.........No
Seizure disorder..... .... Yes.........No
Migraines............. .... Yes.........No

Psychiatric:

Treatment for psychiatric disorder .. .. Yes ....No

Skin: ... .

Skin cancer...................... ....Yes ....No

Patient Signature____Date_______________
Patient Signature ____Date______________
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