

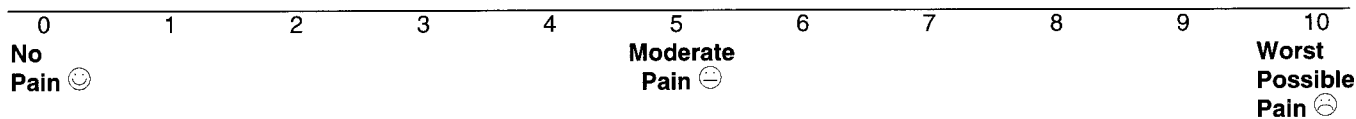
# System Review

NAME: \_\_\_\_\_

DATE: \_\_\_\_\_

ACCT #: \_\_\_\_\_

## Pain Scale (circle one)



## SYSTEMIC / HEENT

If answered yes, please explain:

- Y  N  Fatigue \_\_\_\_\_
- Y  N  Weight Gain / Weight Loss \_\_\_\_\_
- Y  N  Insomnia \_\_\_\_\_
- Y  N  Dry Eyes \_\_\_\_\_
- Y  N  Dry Mouth \_\_\_\_\_
- Y  N  Oral Ulcers \_\_\_\_\_

## GI

- Y  N  Heartburn \_\_\_\_\_
- Y  N  Abdominal Pain \_\_\_\_\_
- Y  N  Constipation (frequent) \_\_\_\_\_
- Y  N  Diarrhea (frequent) \_\_\_\_\_
- Y  N  Rectal Bleeding \_\_\_\_\_

## GU / GYN

- Y  N  Urinary Burning \_\_\_\_\_
- Y  N  Urinary Bleeding \_\_\_\_\_
- Y  N  Menstrual Irregularity \_\_\_\_\_
- Y  N  Menopause \_\_\_\_\_

## CARDIOVASCULAR / PULMONARY

- Y  N  Edema (fluid retention) \_\_\_\_\_
- Y  N  Chest Pain \_\_\_\_\_
- Y  N  Palpitations \_\_\_\_\_
- Y  N  Shortness of Breath \_\_\_\_\_
- Y  N  Cough \_\_\_\_\_
- Y  N  Wheezing \_\_\_\_\_

# System Review

NAME: \_\_\_\_\_

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## NEUROLOGIC / PSYCHIATRIC

- Y  N  Numbness / Tingling /  
Burning Sensation \_\_\_\_\_
- Y  N  Poor Balance \_\_\_\_\_
- Y  N  Muscle Weakness \_\_\_\_\_
- Y  N  Frequent Headache \_\_\_\_\_
- Y  N  Anxiety \_\_\_\_\_
- Y  N  Depression \_\_\_\_\_

## HEMATOLOGIC / ENDOCRINOLOGIC / DERMATOLOGY

- Y  N  Easily Bruises \_\_\_\_\_
- Y  N  Enlarged Lymph Nodes \_\_\_\_\_
- Y  N  Heat Intolerance \_\_\_\_\_
- Y  N  Cold Intolerance \_\_\_\_\_
- Y  N  Hair Loss \_\_\_\_\_
- Y  N  Rash \_\_\_\_\_

## MS - SK

- Y  N  Joint Swelling \_\_\_\_\_
- Y  N  Joint Pain \_\_\_\_\_
- Y  N  Muscle Pain \_\_\_\_\_
- Y  N  Broken Bones \_\_\_\_\_
- Y  N  Neck / Back Pain \_\_\_\_\_

## SOCIAL HISTORY

# Alcoholic Beverages / week \_\_\_\_\_ # Cigarettes / Cigars (circle one) / day \_\_\_\_\_

Describe regular exercise program: \_\_\_\_\_

Sources of stress: \_\_\_\_\_

## PAST HISTORY

List any hospitalizations, new diagnoses, doctor visits since last seen in our office:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_