

SYSTEM REVIEW

Patient Name \_\_\_\_\_

| Check (√) Appropriate Box – Please check each box |    |        | Use this space for continuation of Present Illness and/or to Describe Symptoms |
|---|----|--------|--|
| Yes   | No | Unsure |  |
|   |    |        | Chills   |
|   |    |        | Fever  |
|   |    |        | Weight Change  |
|   |    |        | <b>Eyes:</b>   |
|   |    |        | Eye Pain   |
|   |    |        | Loss of Vision   |
|   |    |        | Double Vision  |
|   |    |        | <b>ENT:</b>  |
|   |    |        | Ear Pain   |
|   |    |        | Deafness   |
|   |    |        | Bleeding Nose  |
|   |    |        | Hoarseness   |
|   |    |        | Difficulty Swallowing  |
|   |    |        | <b>Cardiorespiratory:</b>  |
|   |    |        | Cough  |
|   |    |        | Sputum   |
|   |    |        | Blood with Coughing  |
|   |    |        | Leg Swelling   |
|   |    |        | <b>Gastrointestinal:</b>   |
|   |    |        | Poor appetite  |
|   |    |        | Nausea & Vomiting  |
|   |    |        | Constipation   |
|   |    |        | Diarrhea   |
|   |    |        | Change in Bowel Habits   |
|   |    |        | Jaundice   |
|   |    |        | Abdominal Pain   |
|   |    |        | Anal Bleeding  |
|   |    |        | Anal Pain  |
|   |    |        | <b>Genitourinary:</b>  |
|   |    |        | Frequency  |
|   |    |        | Urgency  |
|   |    |        | Blood in Urine   |
|   |    |        | Stones or Gravel   |
|   |    |        | Urethral Discharge   |
|   |    |        | Incontinence   |
|   |    |        | <b>Neuropsychiatric:</b>   |
|   |    |        | Headaches  |
|   |    |        | Seizures   |
|   |    |        | Paralysis  |
|   |    |        | Anxiety  |
|   |    |        | Depression   |
|   |    |        | Disturbance of Gait or Speech  |
|   |    |        | Disturbing Feelings or Thoughts  |
|   |    |        | <b>Musculoskeletal:</b>  |
|   |    |        | Back Pain  |
|   |    |        | Bone Infection(s)  |
|   |    |        | Skeletal Deformities   |
|   |    |        | Joint Pain or Swelling   |
|   |    |        | Varicose Veins   |
|   |    |        | Leg Ulcers   |
|   |    |        | <b>OB/GYN:</b>   |
|   |    |        | Number of Pregnancies # _____  |
|   |    |        | Number of Vaginal Deliveries # _____   |
|   |    |        | Non-Menstrual Bleeding   |
|   |    |        | Excessive Menstrual Flow   |
|   |    |        | Irregular Menstrual Flow   |
|   |    |        | Pelvic Pain  |