

## System Review

Do you have any of the following:

- |  |   |   |   |
|--|---|---|---|
| <input type="checkbox"/> Heart problems      | <input type="checkbox"/> Thyroid disease      | <input type="checkbox"/> Gallstones     | <input type="checkbox"/> Colitis        |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Stroke               | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Bone disease   |
| <input type="checkbox"/> Asthma              | <input type="checkbox"/> Paralysis            | <input type="checkbox"/> Kidney stones  | <input type="checkbox"/> Back problems  |
| <input type="checkbox"/> Emphysema           | <input type="checkbox"/> Migraines            | <input type="checkbox"/> Gout           | <input type="checkbox"/> Eye problems   |
| <input type="checkbox"/> TB                  | <input type="checkbox"/> Epilepsy             | <input type="checkbox"/> Arthritis      | <input type="checkbox"/> Ear problems   |
| <input type="checkbox"/> Pneumonia           | <input type="checkbox"/> Meningitis           | <input type="checkbox"/> Blood clots    | <input type="checkbox"/> Mental illness |
| <input type="checkbox"/> Pleurisy            | <input type="checkbox"/> Hepatitis            | <input type="checkbox"/> Cancer         | <input type="checkbox"/> Ulcer          |
| <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Elevated Cholesterol | <input type="checkbox"/> Liver Disease  |   |

### General

- Recent wt. Gain \_\_\_\_\_  
Recent wt. Loss \_\_\_\_\_  
 Fatigue  
 Weakness  
 Fever

### Eyes

- Pain  
 Redness  
 Dryness  
 Loss of vision  
 Double or blurred vision

### Mouth

- Dryness  
 Sore tongue  
 Loss of taste  
 Bleeding gums  
 Sores in mouth

### Muscles

- Joint pain  
 Joint swelling  
 Muscle weakness  
 Muscle tenderness  
 Morning stiffness

### Nose

- Dryness  
 Nosebleeds  
 Loss of smell

### Nervous System

- Headaches  
 Dizziness  
 Fainting  
 Paralysis  
 Memory loss  
 Loss of consciousness

### Neck

- Swollen glands  
 Tender glands

### Blood

- Anemia  
 Bleeding tendencies

### Ears

- Ringing in ears  
 Loss of hearing

### Throat

- Hoarseness  
 Difficulty swallowing  
 Frequent sore throats

### Kidney / Bladder

- Bloody urine  
 Cloudy urine  
 Rash / ulcer  
 Difficulty urinating  
 Frequent urination  
 Nighttime urination  
 Vaginal dryness  
 Pain/burning w/urination  
 Prostate problems  
 Sexual difficulty  
 Discharge from penis/vagina

### Heart and Lungs

- Pain in chest  
 Irregular heartbeat  
 Shortness of breath  
 Difficulty breathing at night  
 Swollen legs or feet  
 Heart murmur  
 Cough  
 Coughing of blood  
 Wheezing  
 Night sweats

### Stomach and Intestines

- Heartburn  
 Nausea  
 Vomiting blood  
 Stomach pain  
 Yellow jaundice  
 Constipation  
 Diarrhea  
 Blood in stools  
 Black stools

### Skin

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Color changes in hands/feet | <input type="checkbox"/> Sun sensitivity | <input type="checkbox"/> Easy bruising |
| <input type="checkbox"/> Redness                     | <input type="checkbox"/> Nodules         | <input type="checkbox"/> Hives         |
| <input type="checkbox"/> Rash                        | <input type="checkbox"/> Hair loss       |  |