System Review

Do you have any of the following:

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

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

Ears

- ☐ Ringing in ears
- ☐ Loss of hearing

Nervous System

- ☐ Headaches
- ☐ Dizziness
- ☐ Fainting
- ☐ Paralysis
- ☐ Memory loss
- ☐ Loss of consciousness

Neck

- ☐ Swollen glands
- ☐ Tender glands

Blood

- ☐ Anemia
- ☐ Bleeding tendencies

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

- ☐ Color changes in hands/feet
- ☐ Redness
- ☐ Rash
- ☐ Sun sensitivity
- ☐ Nodules
- ☐ Hair loss
- ☐ Easy bruising
- ☐ Hives

Patient Current Medication Form

***List all medications you are taking, include over-the-counter medications (e.g., Aspirin, antacids, vitamins and herbals).**

☐ **I am not Allergic to any medications**

Medication Allergy	Reaction (what happens when you take this medication)

☐ I am not taking any medications at this time.

Medication:________________________ Strength:________ How often: ☐ daily ☐ 2 times ☐ 3 times ☐ 4 times
Reason for taking:____ Date started:______________
Doctor that prescribed this medication: ____

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Reason for taking:____ Date started:______________
Doctor that prescribed this medication: ____

Patient Signature: ____ Date: ____/____/____