REVIEW OF SYSTEMS UPDATE (Circle if YES)

Please circle any problems you are currently having

METABOLIC / ENDOCRINE
Weight change
Warmer/Colder than others
Increased sweating
Goiter
Increased thirst
Increased urination
Skin, Hair, Nail changes

HEAD, EYES, EARS, NOSE, THROAT
Headache
Hearing problem
Eye problem
Ear pain
Dizziness
Nasal drainage
Sore mouth/throat

CARDIOVASCULAR
Chest pain
Fast/Irregular heartbeat
Ankle swelling
High blood pressure
Calf pain with walking

RESPIRATORY
Short of breath
Wheezing
Raise phlegm
Cough up blood

URINARY
Blood in urine
Urinary frequency
Pain/Burning with urination
Empty bladder at night
Bladder leakage

FEMALE PATIENTS
Spot or menstruate _____ Yes _____ No
Every _____ days, for _____ days each period.
Age of onset _____ Menopause _____
Last Period _____ Last PAP smear _____
Number of pregnancies _____
Breast changes
Calcium intake
Do you do self breast exam? Yes _____ No _____

MALE PATIENTS
Impotence
Changes in urinary stream
Testicular exam? _____ Scrotal lumps _____

GASTROINTESTINAL
Heartburn
Nausea/Vomiting
Trouble swallowing
Abdominal pain
Blood in stools
Black stools
Jaundice
Change in bowel habit
Constipation
Diarrhea
Belching/Gas
Hemorrhoids

MUSCULOSKELETAL / NEURO / PSYCHIATRIC
Back pain
Joint pain
Stiff neck
Muscle weakness/paralysis
Tremor/Shakes
Numbness/Tingling
Convulsions
Fainting
Depression/Anxiety
Stress
Sleep poorly

BLOOD / LYMPHATIC / CONSTITUTIONAL
Bleeding/Bruising
Anemia
Enlarged glands
Fever

ALLERGIC / IMMUNOLOGIC
Hayfever
Asthma
Rashes/Hives
Allergies
Vaccines
- Tetanus No _____ Yes (when) _____
- Pneumonia No _____ Yes (when) _____
- Hepatitis B No _____ Yes (when) _____
- Flu No _____ Yes (when) _____
- MMR No _____ Yes (when) _____

Please list the other people in your household:

_____
_____
_____
_____
_____

REMARKS _____
_____
_____
_____
_____
_____

NAME _____ **BD** _____ **DATE**