SYSTEM REVIEW:

Document the positive & pertinent negative responses
- For an "EXTENDED" system review - at least 2 systems
- For a "COMPLETE" system review - at least 10 systems (Dictate responses to pertinent systems, then state: "All other systems negative")

• CONSTITUTIONAL SYMPTOMS
- Good general health lately ..... No Yes
- Recent weight change ..... No Yes
- Fever ..... No Yes
- Fatigue ..... No Yes
- Headaches ..... No Yes

• EYES
- Eye disease or injury ..... No Yes
- Wear glasses/cootact lens ..... No Yes
- Blurred or double visioo ..... No Yes
- Glaucoma ..... No Yes

• EARS/NOSE/MOUTH/THROAT
- Hearing loss or ringing ..... No Yes
- Earaches or draining ..... No Yes
- Chronic sinus problems or rhinitis ..... No Yes
- Nose bleeds ..... No Yes
- Mouth sores ..... No Yes
- Bleeding gums ..... No Yes
- Bad breath or bad taste ..... No Yes
- Sore throat or voice change ..... No Yes
- Swollen glands in neck ..... No Yes

• CARDIOVASCULAR
- Heart trouble ..... No Yes
- Chest pain or angina pectoris ..... No Yes
- Palpitatioo ..... No Yes
- Shortness of breath with walking or lying flat ..... No Yes
- Swelling of feet, ankles or hands ..... No Yes

• RESPIRATORY
- Chronic or frequent coughs ..... No Yes
- Spitting up blood ..... No Yes
- Shortness of breath ..... No Yes
- Asthma or wheezing ..... No Yes

• GASTROINTESTINAL
- Loss of appetite ..... No Yes
- Change in bowel movements ..... No Yes
- Nausea or vomiting ..... No Yes
- Frequent diarrhea ..... No Yes
- Painful bowel movements or constipation ..... No Yes
- Rectal bleeding or blood in stool ..... No Yes
- Abdominal pain or heartburn ..... No Yes
- Peptic ulcer (stomach or duodenal) ..... No Yes

• GENITOURINARY
- Frequent urinatioo ..... No Yes
- Burning or painful urination ..... No Yes
- Blood in urine ..... No Yes
- Change in force of strain when urinating ..... No Yes
- Incontinence or dribbling ..... No Yes
- Kidney stooes ..... No Yes
- Sexual difficulty ..... No Yes
- Male - testicle pain ..... No Yes
- Female - pain with periods ..... No Yes
- Female - irregular periods ..... No Yes
- Female - vaginal bleeding ..... No Yes
- Female - # of pregnancies _____ # of miscarriages _____
- Female - date of last pap smear _____

• MUSCULOSKELETAL
- Joint Pain ..... No Yes
- Joint stiffness or swelling ..... No Yes
- Weakness of muscles or joints ..... No Yes
- Muscle pain or cramps ..... No Yes
- Back pain ..... No Yes
- Cold extremities ..... No Yes
- Difficulty in walking ..... No Yes

• INTEGUMENTARY (skin, breast)
- Rash or itching ..... No Yes
- Change in skin color ..... No Yes
- Change in hair or nails ..... No Yes
- Varicose Veins ..... No Yes
- Breast pain ..... No Yes
- Breast lump ..... No Yes
- Breast discharge ..... No Yes

• NEUROLOGICAL
- Frequent or recurring headaches ..... No Yes
- Light headed or dizzy ..... No Yes
- Convulsions or seizures ..... No Yes
- Numbness or tingling sensations ..... No Yes
- Tremors ..... No Yes
- Paralysis ..... No Yes
- Stroke ..... No Yes
- Head injury ..... No Yes

• PSYCHIATRIC
- Memory loss or confusioo ..... No Yes
- Nervousness ..... No Yes
- Depressioo ..... No Yes
- Insomnia ..... No Yes

• ENDOCRINE
- Glandular or hormooe problem ..... No Yes
- Thyroid disease ..... No Y
- Diabetes ..... No Yes
- Excessive thirst or urination ..... No Yes
- Heat or cold intolerance ..... No Yes
- Skin becoming dryer ..... No Yes
- Change in hat or glove size ..... No Yes

• HEMATOLOGIC/LYMPHATIC
- Slow to heal after cuts ..... No Yes
- Bleeding or bruising tendency ..... No Yes
- Anemia ..... No Yes
- Phlebitis ..... No Yes
- Past transfusion ..... No Yes
- Enlarged glands ..... No Yes

• ALLERGIC/IMMUNOLOGIC

History of skin reaction or other adverse reaction to:
- Penicillin or other antibiotics ..... No Yes
- Morphine, Demerol, or other narcotics ..... No Yes
- Novocaine or other anesthetics ..... No Yes
- Aspirin or other pain remedies ..... No Yes
- Tetanus antitoxin or other serums ..... No Yes
- Iodine methiolate or other antiseptics ..... No Yes

Other drugs/medications _____

Known food allergies _____