

SYSTEM REVIEW

Patient Name _____ **Date** _____

CONSTITUTIONAL SYMPTOMS

Good general health latelyNo Yes
 Recent weight changeNo Yes
 FatigueNo Yes
 HeadacheNo Yes

EYES

Eye disease or injuryNo Yes
 Blurred or double visionNo Yes
 Loss of visionNo Yes
 GlaucomaNo Yes

EARS / NOSE / MOUTH / THROAT

Hearing loss or ringingNo Yes
 Earache or drainageNo Yes
 Chronic sinus problem or rhinitisNo Yes
 Swollen glands in neckNo Yes
 Difficulty of swallowingNo Yes

CARDIOVASCULAR

PalpitationNo Yes
 Swelling of feet, ankles, or handsNo Yes

RESPIRATORY

Shortness of breathNo Yes

GASTROINTESTINAL

Nausea or vomitingNo Yes
 Abdominal pain or heartburnNo Yes

GENITOURINARY

Incontinence or dribblingNo Yes
 Kidney stone(s)No Yes

MUSCULOSKELETAL

Joint painNo Yes
 Muscle pain or crampsNo Yes
 Back painNo Yes
 Difficulty in walkingNo Yes
 Neck painNo Yes

SKIN

Rash or itchingNo Yes

NEUROLOGIC

Frequent or recurring headachesNo Yes
 Lightheadedness or dizzinessNo Yes
 Convulsions or seizuresNo Yes
 Numbness or tingling sensationsNo Yes
 TremorsNo Yes
 StrokeNo Yes
 Head injuryNo Yes

PSYCHIATRIC

Memory loss or confusionNo Yes
 NervousnessNo Yes
 DepressionNo Yes
 InsomniaNo Yes

ENDOCRINE

Excessive thirst or urinationNo Yes
 Heat or cold intoleranceNo Yes

HEMATOLOGIC

Bleeding or bruising tendencyNo Yes
 AnemiaNo Yes

ALLERGIC / IMMUNOLOGIC

History of skin reaction or other adverse reaction to:
 Penicillin or other antibioticsNo Yes
 Other drugs or medicationsNo Yes

If yes, please list: _____

Known food allergiesNo Yes

If yes, please list: _____