

DATE: _____

ACCT: _____

PATIENT: _____

SYSTEMS REVIEW

In the left-hand column, please indicate with a (C) Conditions you have now or with a (P) the conditions you have had in the Past. If neither apply, mark (NA), don't leave any blanks.

	FOR DOCTORS'S USE ONLY	
	DR. REVIEWED	SYSTEMS SYMPTOMS
High Blood Pressure _____	_____	General Weight changes, fatigue, anorexia, weakness, fever, chills changes in activity
Dizziness/Fainting _____	_____	Skin Rashes, eruptions, changes in warts or moles, pigmentation changes, bruising, itching, hair loss, nail changes
Insomnia _____	_____	Head Trauma, headaches, dizziness, light headed
Low Resistance _____	_____	Eyes Change in acuity of vision, use of corrective lenses, loss of diplopia, photophobia, blurred vision, scotomata, pain, excessive lacrimation, redness, discharge
Tension _____	_____	Nose Rhinorrhea, epistaxis, allergies, airway obstruction
Confusion _____	_____	Mouth & Throat Ulcers, tooth pain/extractions, temporomandibular joint (TMJ), pain, gum bleeding, soreness, swelling, enlarged glands, sore throat, strep throat
Fatigue _____	_____	Neck Stiffness, lumps/swelling/masses, pain
Ulcers _____	_____	Lungs Cough (productive/nonproductive), hemoptysis, dyspnea, pain with respiration, wheezing, night sweats
Eye/Vision Problems _____	_____	Cardiac Palpitations, chest pain, orthopnea, paroxysmal nocturnal dyspnea, ankle swelling, syncope
Ear/Hearing Problems _____	_____	Vascular Raynaud's phenomenon, intermittent claudication, hypertension, rheumatic fever
Difficulty Breathing _____	_____	Breasts Self-examination frequency/results, pain, nipple discharge, lumps/masses, skin dimpling
Heart Problems _____	_____	Gastrointestinal Unusual diet, dysphagia, regurgitation, dyspepsia, nausea, vomiting, belching, abdominal pain, cramps, hematemesis, stool color changes, diarrhea, constipation, change in bowel habits, jaundice, abdominal swelling
Loss of Bladder Control _____	_____	Genitourinary Polyuria, nocturia, oliguria, dysuria, urgency, incontinence, urine color changes, hematuria, sexually transmitted diseases, dyspareunia, scrotal mass (male), hernia
Constipation _____	_____	Endocrine Polydipsia, polyphagia, temperature intolerance, tremors, goiter, alopecia, hirsutism, menstruation, history, pregnancy history, dysmenorrhea, premenstrual syndrome, climacteric
Diarrhea _____	_____	Hematopoietic Anemia, abdominal bleeding, lymph node enlargement/pain
Digestion Problems _____	_____	Musculoskeletal Bone/joint pain, swelling, joint deformity, trauma, restricted range of motion, weakness, atrophy
Nausea _____	_____	Neurological Cranial nerve deficits, seizures, loss of consciousness, paralysis, tremors, ataxia, loss of balance, numbness, paresthesia
Female Problems _____	_____	Psychological Mood swings, depression, anxiety, phobias
Prostate Problems _____		
Diabetes _____		
Hands/Feet Cold _____		
Hand Tremors _____		
Loss of Memory _____		
Nervousness _____		
Sweaty Palms _____		
Speech Difficulty _____		
Anxiety _____		
Depression _____		
Irritability _____		

Please identify all facilities/providers you have seen for these conditions and those you are currently seeing, if any, for your presenting problem(s)

PROBLEM LIST

DR NAME/ FACILITY	PROBLEM	TYPE OF TREATMENT RECEIVED	FROM WHEN TO WHEN

FOR DOCTORS USE ONLY

- Reviewed External H P
 Release Records H P
 Request Records H P

EXTERNAL DX'D: _____

DISABILITIES: _____

IMPAIRMENTS: _____