SYSTEMIC REVIEW

Do you have any of the following?

(Please circle No or Yes or ask for assistance.)

General:

Good general health most of your life?..... No Yes
Living Will / Advanced Directives?..... No Yes
Recent weight change?..... No Yes
Weight loss desired?..... No Yes

Skin:

Varicose Veins?..... No Yes
Raised moles?..... No Yes
Abnormal pigmentation / color?..... No Yes
Rash, hives or eczema?..... No Yes
Skin disease?..... No Yes
Jaundice?..... No Yes

Head-Eyes-Ears-Nose-Throat:

Glasses / Contact Lenses / Poor Vision?... No Yes
Eye disease / injury / problems?..... No Yes
Glaucoma?..... No Yes
Recurrent headaches?..... No Yes
History of unconsciousness/ concussions? ...No Yes
Ear disease / impaired hearing?..... No Yes
Chronic dizziness?..... No Yes
Chronic sinus problems?..... No Yes
Recurrent nose bleeds?..... No Yes
Enlarged glands?..... No Yes

Respiratory / Chest:

Cold / Upper respiratory infection now?..... No Yes
Spitting up blood?..... No Yes
Chronic or frequent cough?..... No Yes
History of asthma,wheezing or tuberculosis? No Yes
Difficulty breathing?..... No Yes
History of lung problems &/or pneumonia?..... No Yes
Breast disease or masses?..... No Yes
Last Mammogram Normal (When)?..... No Yes

Cardiovascular:

Chest pain or angina pectoris?..... No Yes
Shortness of breath while lying or walking?..... No Yes
Heart trouble or history of heart attacks?..... No Yes
High blood pressure or hypertension?..... No Yes
Swelling of hands, feet or ankles?..... No Yes
Heart murmur?..... No Yes

Gastrointestinal (GI):

Vomiting blood?..... No Yes
Peptic, stomach or duodenal ulcer?..... No Yes
Chronic heartburn or indigestion?..... No Yes
Cramping or pain in the abdomen?..... No Yes
Gallbladder disease?..... No Yes
History of liver disease or hepatitis?..... No Yes
History of intestinal disease?..... No Yes
Bleeding with bowel movements?..... No Yes
Black tarry stools / bowel movements?..... No Yes
Hemorrhoids or piles?..... No Yes

Genitourinary (GU):

Loss of urine / incontinence?..... No Yes
Frequent night time urinating?..... No Yes
Burning or painful urination?..... No Yes
Blood in urine or kidney stones?..... No Yes
History of any kidney disease?..... No Yes

Hematologic:

Any blood disease?..... No Yes
History of anemia?..... No Yes
Slow to heal cuts, or easy to bleed / bruise? ...No Yes
History of blood transfusions?..... No Yes

Neuro-Psychiatric:

History of or need for psychiatric care?..... No Yes
Suicidal Ideas?..... No Yes
History of excessive alcohol use / alcoholism? No Yes
History of convulsions, epilepsy or paralysis? No Yes

Endocrine / Other:

Diabetes type 1, 2 or during pregnancy?..... No Yes
Thyroid Problems?..... No Yes
Change in hair growth / distribution?..... No Yes
Have you become colder or your skin dryer? ..No Yes
Arthritis or any rheumatologic disease?..... No Yes
History of cancer or precancerous disease? ...No Yes

GYNECOLOGIC:

Age periods started_____
#Days between periods_____
#Days periods last_____
First Day Last Menstrual Period_____
When was last Pap smear?_____
Last Pap smear was normal?..... No Yes
Are your periods regular?..... No Yes
Any pain with your periods?..... No Yes
Are you sexually active?..... No Yes
Any pain with sex?..... No Yes
Any vaginal discharge or itching?..... No Yes
Current HIV infection?..... No Yes
Past Gonorrhea or Chlamydia?..... No Yes
Past Trichomoniasis (Trich)?..... No Yes
Past genital warts or Condyloma?..... No Yes
Past HPV or genital herpes?..... No Yes
Any other past STDs or VD?..... No Yes
Are you using contraception?..... No Yes
If so, what type / name?_____

OBSTETRICS:

Number of total pregnancies _____
Number of total births_____
Number of miscarriages &/or abortions _____
Number of children alive_____

----------fill in the data below regarding your births----------

	Mo/Yr	Preterm?	Vaginal?	Weight	Sex	Complications
1]						
2]						
3]						
4]						
5]						

ANYTHING ELSE YOU WANT TO ADD?..... No Yes

_____

Patient will update doctor as need be?..... No Yes
Print patient's name_____
Todays date_____
Patient's signature(guardian?) X_____
Dr. Taras' signature_____