**Systems Review Patient Name: Date:**

**Circle** any conditions that are **presently** causing you a problem.

**Underline** those that have caused you problems in the **past**.

|  |  |  |
| --- | --- | --- |
| **GENERAL SYMPTOMS** | **RESPIRATORY** | **GENITOURINARY** |
| Fever  Sweats  Fainting  Sleep disturbance  Fatigue  Nervousness  Weight loss  Weight gain | Chronic cough  Spitting up phlegm  Spitting up blood  Chest pain  Wheezing  Difficulty breathing  Asthma | Frequent urination  Painful urination  Blood in urine  Pus in urine  Kidney infection  Prostate trouble  Uncontrollable urine flow |
| **NEUROLOGICAL** | **CARDIOVASCULAR** | **GASTROINTESTINAL** |
| Visual disturbance  Dizziness  Fainting  Convulsions  Headache  Numbness  Neuralgia (nerve pain)  Poor coordination  Weakness | Rapid beating heart  Slow beating heart  High blood pressure  Low blood pressure  Pain over heart  Hardening of arteries  Swollen ankles  Poor circulation  Palpitations  Cold hand or feet  Varicose veins | Poor appetite  Difficult digestion  Heartburn  Ulcers  Nausea  Vomiting  Constipation  Diarrhea  Blood in stool  Gallbladder/jaundice  Colitis |
| **EYES, EARS, NOSE, THROAT** | **MUSCLE & JOINT** | **FOR WOMEN ONLY** |
| Eye pain  Double vision  Ringing in ears  Deafness  Nosebleeds  Trouble swallowing  Hoarseness  Sinus infection  Nasal drainage  Enlarged glands | Neck pain  Low back pain  Arm pain  Shoulder pain  Leg pain  Knee pain  Foot pain  Pain/numbness down arms or legs  Pain between shoulders swollen joints  Spinal curvature  Arthritis  Fractures | Painful menstruation  Hot flashes  Irregular cycle  Cramps or back pain  Vaginal discharge  Nipple discharge  Lumps in breast  Menopausal symptoms  Birth control pills  Miscarriages  Complications with pregnancy  Pregnant? Y / N Week?  Other: |