

System Review: Document the positive & pertinent negative responses

Name: \_\_\_\_\_

- 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 / contact lens ..... No Yes  
 Blurred or double vision ..... No Yes  
 Glaucoma ..... No Yes

**Ears/Nose/Mouth/Throat**

Hearing loss or ringing ..... No Yes  
 Earaches or drainage ..... No Yes  
 Chronic sinus problem 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  
 Palpitation ..... 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 of 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 urination ..... 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 stones ..... No Yes  
 Sexual difficulty ..... No Yes  
 Male – testicle pain ..... No Yes  
 Female – pain with periods ..... No Yes  
 Female – Irregular periods ..... No Yes  
 Female – vaginal discharge ..... No Yes  
 Female - # pregnancies \_\_\_\_ # 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  
 Lightheaded 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 confusion ..... No Yes  
 Nervousness ..... No Yes  
 Depression ..... No Yes  
 Insomnia ..... No Yes

**Endocrine**

Glandular or hormone problem ..... No Yes  
 Thyroid disease ..... No Yes  
 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  
 Novocain or other anesthetics ..... No Yes  
 Aspirin or other pain remedies ..... No Yes  
 Tetanus antitoxin or other serums ..... No Yes  
 Iodine, merthiolate or other antiseptic ..... No Yes  
 Other drugs/medications \_\_\_\_\_  
 Known food allergies \_\_\_\_\_