

SYSTEMIC REVIEW: Do you have any of the following?			
<u>General:</u>		<u>Genitourinary:</u>	
Recent weight change?	No Yes	Loss of urine	No Yes
Good general health most of your life?	No Yes	Frequent urination	No Yes
<u>Head-eye-ear-nose-throat:</u>		Night time urination	
Eye disease or injury	No Yes	Burning or painful urination	No Yes
Do you wear glasses?	No Yes	Blood in urine	No Yes
Double vision	No Yes	Kidney trouble	No Yes
Headaches	No Yes	Kidney stones	No Yes
Glaucoma	No Yes	Bright's disease	No Yes
Itching eyes or nose	No Yes	<u>Locomotor-Musculoskeletal:</u>	
Sneezing or runny nose	No Yes	Varicose veins	No Yes
Nosebleeds	No Yes	Weakness of muscles or joints	No Yes
Chronic sinus trouble	No Yes	Any difficulty in walking	No Yes
Ear disease	No Yes	Any pain in calves or buttocks when walking	No Yes
Impaired hearing	No Yes	...relieved by rest?	No Yes
Dizziness or transient unconscious episodes	No Yes	<u>Neuro-psychiatric:</u>	
<u>Neck</u>		Have you ever had psychiatric care?	
Stiffness	No Yes	Have you been advised to see a psychiatrist?	
Thyroid trouble	No Yes	Do you have, or ever had, fainting spells?	
Enlarged glands		Convulsions	
<u>Respiratory:</u>		Paralysis	
URI (cold) now	No Yes	<u>Hematological:</u>	
Spitting up blood	No Yes	Are you slow to heal after cuts?	
Chronic or frequent cough	No Yes	Blood disease	
Asthma or wheezing	No Yes	Anemia	
Difficulty breathing	No Yes	Phlebitis	
Any trouble with lungs	No Yes	Excessive bleeding after tooth extraction or surgery?	
Pleurisy or pneumonia	No Yes	Have you had abnormal bruising or bleeding?	
<u>Cardiovascular</u>		<u>Allergic:</u>	
Chest pain or angina pectoris	No Yes	Any allergies, including medication?	
Shortness of breath walking or lying down	No Yes	<u>Endocrine:</u>	
Difficulty walking two blocks	No Yes	Thyroid disease	
Heart trouble or heart attacks	No Yes	Hormonal therapy	
High blood pressure	No Yes	Change in hat or glove size	
Swelling of hands, feet or ankles	No Yes	Change in hair growth	
Awakening in the night smothering	No Yes	Has your skin been colder or dryer than before?	
Heart murmur	No Yes	<u>Skin</u>	
<u>Gastrointestinal</u>		Skin disease	
Peptic ulcer (stomach or duodenal)	No Yes	Jaundice	
Vomiting blood or food	No Yes	Hives, eczema or rash	

Gallbladder disease	No Yes		Frequent infection or boils	No Yes
Liver trouble	No Yes		Abnormal pigmentation	No Yes
Hepatitis	No Yes		<u>Gynecological:</u>	
Painful bowel movements	No Yes		Any pain with your periods?	No Yes
Bleeding with bowel movements	No Yes		Age periods started _____	
Black stools	No Yes		How long do periods last? _____	
Hemorrhoids or piles	No Yes		Number of pregnancies _____	
Recent change in bowel habits	No Yes		Number of miscarriages _____	
Frequent diarrhea	No Yes		Date and results of last cancer smear _____	
Heartburn or indigestion	No Yes		Frequency of periods; every _____ days	
Cramping or pain In the abdomen	No Yes		Number of children _____ Ages _____	
Does food stick in throat?	No Yes		Date of first day of last period _____	

ALLERGIES AND SENSITIVITIES				What other drugs or food? _____
	Circle one			
Penicillin or other antibiotics	Yes know	No	Don't	_____
Morphine, codeine, Demerol or other narcotics	Yes know	No	Don't	_____
Novocain or other anesthetics	Yes know	No	Don't	_____
Aspirin, Empirin or other pain remedies	Yes know	No	Don't	_____
Sulfa drugs	Yes know	No	Don't	_____
Tetanus antitoxin or other serums	Yes know	No	Don't	_____
Adhesive tape	Yes know	No	Don't	_____
Iodine or merthiolate	Yes know	No	Don't	_____
Any other drug or medication	Yes know	No	Don't	_____
Any foods, such as eggs, milk or chocolate	Yes know	No	Don't	_____
<u>Drugs Recently Taken During the past six months, has patient taken:</u>				
Cortisone	Yes know	No	Don't	
ACTH	Yes know	No	Don't	
Anticoagulants	Yes know	No	Don't	
Tranquilizers	Yes know	No	Don't	
Hypotensives (high blood pressure medication)	Yes know	No	Don't	
Aspirin	Yes know	No	Don't	
Has the patient ever received treatment for asthma, rheumatism or rheumatic fever?	Yes know	No	Don't	

Source of information, if other than patient: _____

Signature of person acquiring this information: _____

Doctor

Date

Signature of patient