

System Review

General Questions	Cardiovascular	Kidneys & Urinary Tract	Musculoskeletal
<input type="checkbox"/> Weight Loss <input type="checkbox"/> Weight Gain <input type="checkbox"/> Change in Sleep Patterns <input type="checkbox"/> Change in activity	<input type="checkbox"/> Angina <input type="checkbox"/> Chest Pain <input type="checkbox"/> Murmurs <input type="checkbox"/> Ankle Swelling <input type="checkbox"/> Awakening Short of Breath <input type="checkbox"/> Cardiac Catheterization <input type="checkbox"/> Cold Hands or Feet <input type="checkbox"/> Congenital Heart Defects <input type="checkbox"/> Dizziness when Standing Quickly <input type="checkbox"/> Heart Attacks <input type="checkbox"/> Heart Failure <input type="checkbox"/> High/Low Blood Pressure <input type="checkbox"/> Irregular Heart Rate <input type="checkbox"/> Purple Fingers or Lips <input type="checkbox"/> Leg Pain that Resolves w/ Rest <input type="checkbox"/> Heart Palpitations <input type="checkbox"/> Varicose Veins	<input type="checkbox"/> Blood in Urine <input type="checkbox"/> Brown Urine <input type="checkbox"/> Dribbling after Urination <input type="checkbox"/> Painful Urination <input type="checkbox"/> Excessive Thirst <input type="checkbox"/> Involuntary Urination/Incontinence <input type="checkbox"/> Urinating Frequently (day) <input type="checkbox"/> Urinating Frequently (night) <input type="checkbox"/> Urine Hesitancy <input type="checkbox"/> Weak Flow <input type="checkbox"/> Frequent Bladder Infections <input type="checkbox"/> Kidney Disease <input type="checkbox"/> Kidney Stone	<input type="checkbox"/> Anemia <input type="checkbox"/> Back Pain <input type="checkbox"/> Gout <input type="checkbox"/> Neck Pain <input type="checkbox"/> Arthritis <input type="checkbox"/> Bursitis <input type="checkbox"/> Joint Aches <input type="checkbox"/> Tendonitis <input type="checkbox"/> Abnormal Blood Counts <input type="checkbox"/> Blood Clots in Legs/Lungs <input type="checkbox"/> Bone Marrow Biopsy <input type="checkbox"/> Easy Bruising <input type="checkbox"/> Joint Swelling <input type="checkbox"/> Morning Stiffness <input type="checkbox"/> Muscle Aches <input type="checkbox"/> Easy Bleeding
Neurologic & Psychiatric		Endocrine	Gastrointestinal
<input type="checkbox"/> Anxiety <input type="checkbox"/> Headaches <input type="checkbox"/> Depression <input type="checkbox"/> Meningitis <input type="checkbox"/> Paralysis <input type="checkbox"/> Seizure <input type="checkbox"/> Stroke <input type="checkbox"/> Tingling <input type="checkbox"/> Tremors <input type="checkbox"/> Memory Loss <input type="checkbox"/> Fainting Spells, Dizziness <input type="checkbox"/> Head Injuries <input type="checkbox"/> Blackouts or near blackouts <input type="checkbox"/> Change in Sensation anywhere on your body <input type="checkbox"/> Localized weakness or Numbness	<input type="checkbox"/> Pleurisy <input type="checkbox"/> Wheezing <input type="checkbox"/> Asthma <input type="checkbox"/> Breathlessness when lying flat <input type="checkbox"/> Prolonged Cough <input type="checkbox"/> Coughing up Blood <input type="checkbox"/> Emphysema <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Pneumonia <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Frequent infections (Bronchitis)	<input type="checkbox"/> Diabetes <input type="checkbox"/> Abnormal Body Hair <input type="checkbox"/> Changes in Skin Texture <input type="checkbox"/> Cold Intolerance <input type="checkbox"/> Heat Intolerance <input type="checkbox"/> History of "borderline" Diabetes <input type="checkbox"/> Increased Loss of Hair <input type="checkbox"/> Rheumatism <input type="checkbox"/> Thyroid Disease	<input type="checkbox"/> Diarrhea <input type="checkbox"/> Reflux <input type="checkbox"/> Ulcers <input type="checkbox"/> Hepatitis <input type="checkbox"/> Gallstones <input type="checkbox"/> Vomiting <input type="checkbox"/> Heartburn <input type="checkbox"/> Indigestion <input type="checkbox"/> Abdominal Pain <input type="checkbox"/> Anal Fissures <input type="checkbox"/> Black Tarry Stools <input type="checkbox"/> Vomiting Blood <input type="checkbox"/> Constipation <input type="checkbox"/> Nausea <input type="checkbox"/> Problems Swallowing <input type="checkbox"/> Hiatal Hernia <input type="checkbox"/> Intestinal Obstruction <input type="checkbox"/> Liver Disease <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Red Blood after a Bowel Movement
Eyes, Ears, Nose & Throat	Respiratory	Male & Female	
<input type="checkbox"/> Hay fever <input type="checkbox"/> Glaucoma <input type="checkbox"/> Polyps <input type="checkbox"/> Allergy <input type="checkbox"/> Cataracts <input type="checkbox"/> Goiter <input type="checkbox"/> Hoarseness <input type="checkbox"/> Double Vision <input type="checkbox"/> Gum Problems <input type="checkbox"/> Eye Problems <input type="checkbox"/> Ear Infections <input type="checkbox"/> Frequent Nosebleeds <input type="checkbox"/> Ringing in your ears <input type="checkbox"/> Sinus Infections <input type="checkbox"/> Swollen Glands	<input type="checkbox"/> Skin	<input type="checkbox"/> Painful Sexual Intercourse <input type="checkbox"/> Loss of Sexual Interest <input type="checkbox"/> Unprotected Sex <input type="checkbox"/> Groin Itching <input type="checkbox"/> Sexually Transmitted Diseases	<input type="checkbox"/> Males Only
	<input type="checkbox"/> Abscess <input type="checkbox"/> Acne <input type="checkbox"/> Boils <input type="checkbox"/> Hives <input type="checkbox"/> Lumps <input type="checkbox"/> Jaundice <input type="checkbox"/> Psoriasis <input type="checkbox"/> Athlete's Foot <input type="checkbox"/> Excessive Body Odor <input type="checkbox"/> Excessive Sweating <input type="checkbox"/> Fungal Infections <input type="checkbox"/> Nail Problems <input type="checkbox"/> Moles - irregular <input type="checkbox"/> Moles - Change / New <input type="checkbox"/> Dandruff <input type="checkbox"/> Oily Skin <input type="checkbox"/> Rashes <input type="checkbox"/> Dry Skin	<input type="checkbox"/> Females Only	<input type="checkbox"/> Males Only
		<input type="checkbox"/> D & C <input type="checkbox"/> Hot Flashes <input type="checkbox"/> Fibroids <input type="checkbox"/> PMS <input type="checkbox"/> Hernia <input type="checkbox"/> Endometriosis <input type="checkbox"/> Abn. Bleeding between cycles <input type="checkbox"/> Abnormal Pap Smear <input type="checkbox"/> Bleeding After Intercourse <input type="checkbox"/> Complications with Pregnancy <input type="checkbox"/> Heavy Bleeding During Cycles <input type="checkbox"/> Ovarian Cysts <input type="checkbox"/> Pelvic Inflammatory Disease <input type="checkbox"/> Postmenopausal Symptoms	<input type="checkbox"/> Hernia <input type="checkbox"/> Bloody Ejaculation <input type="checkbox"/> Inability to complete Intercourse <input type="checkbox"/> Lump on Testicle <input type="checkbox"/> Penile Discharge <input type="checkbox"/> Sterility <input type="checkbox"/> Sores on Penis or Warts <input type="checkbox"/> Prostate Disease <input type="checkbox"/> Testicular Pain <input type="checkbox"/> Testicular Swelling

Patient Name

Age

ID #

Patient Signature

Date

Provider Signature

Date