System Review

Name _____

Constitutional:	□ Fever	□ Weight Loss	□ Anorexia	□ Severe Fatigue
EENT:	□ Thyroid	□ Iritis	□ Conjunctivitis	□ Oral Ulcers
Cardiopulmonary:	□ Dyspnea	□ Cough	□ Hemoptysis	□ Chest pain
Gastrointestinal:	□ Abdominal Pain		□ Blood in Stool	□ Ulcers
	□ Nausea/ Vomiting		□ Changes in Bowel Habits	
Genitourinary:	□ Frequency	□ Burning	□ Hematuria	□ Hesitancy
	□ Menses	□ Sexual Dysfunction		

Allergies:

Psyche: □ Depressive □ Anxious □ Passive □ Obsessive

Lifestyle Issues

Smoking: □ No □ Yes How long _____ How many packs/day _____

Past Smoking History

How long did you smoke, from age _____ to _____

How many years since you quit _____ How many packs per day _____

Alcohol: □ No □ Yes How many drinks per day/year _____

Substance Abuse

Have you ever been treated for substance abuse? □ No □Yes, for what substance _____

Exercise

How many days per week ____ What activities_____How many years _____

Sleep

How many hours per night ___If you awaken at night about how many times _____

Stress

How would you rate personal stress _____How would you rate job stress _____

Nutrition

Are you currently dieting: □ No □ Yes How much coffee/ soda do you drink _____

Are there any problems with your diet, if yes why _____