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

Psyche: □ Depressive □ Anxious □ Passive □ Obsessive

Surgery:

Fracture:

Allergies:

Accidents:

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/tea/soda do you drink ________

How much water do you drink ______________ Do you sweat easy: □ No □ Yes

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