

SYSTEMS REVIEW

Do you have any of the following? Please indicate by circling the appropriate item.

GENERAL

FEVER, SWEATS
RECENT MARKED WEIGHT LOSS OR GAIN

HEAD EYES, EARS, NOSE

FREQUENT HEADACHES
NECK PAIN OR STIFFNESS
GLAUCOMA
EYE PAIN
BLURRING OF VISION
DOUBLE VISION
UNUSUAL SENSITIVITY TO LIGHT
DISCHARGE FROM EYES
HEARING DIFFICULTIES
SINUS PROBLEMS

RESPIRATORY

ASTHMA
CHRONIC COUGH
SPUTUM PRODUCING COUGH
COUGHING UP BLOOD
POSITIVE TB SKIN TEST
ABNORMAL CHEST X-RAY

CARDIAC

HIGH BLOOD PRESSURE
HISTORY OF HEART ATTACK
CHEST PAIN
SHORTNESS OF BREATH
RAPID OR IRREGULAR PULSE
ANKLE SWELLING

VASCULAR

PREVIOUS PHLEBITIS
LEG CRAMPS ON EXERCISE
VARICOSE VEINS

HEMIC-LYMPHATIC

EASY BRUISING
PROLONGED BLEEDING
FREQUENT MINOR INFECTION

GASTROINTESTINAL

ULCERS OF GASTRITIS
SEVERE OR FREQUENT ABDOMINAL PAIN
TARRY BLACK STOOL
YELLOW JAUNDICE
COFFEE GROUND VOMITING

GENITOURINARY

FREQUENT OR PAINFUL URINATION
KIDNEY OR BLADDER INFECTION
KIDNEY STONES

WOMEN

PREGNANT?
ABNORMAL OR IRREGULAR PERIODS
VAGINAL DISCHARGE
DATE OF LAST PERIOD _____
AGE AT WHICH PERIOD STOPPED _____

MUSCULOSKELETAL

GENERALIZED JOINT PAIN
JOINT SWELLING
NECK OR BACK PAIN

ENDOCRINE

DIABETES
THYROID DISORDER
GOUT

NEUROLOGICAL

FAINTING
CONVULSIONS
DIZZINESS
SHAKINESS OR TREMBLING

PSYCHIATRIC

UNDER PSYCHIATRIC CARE
SERIOUS EMOTIONAL PROBLEMS
HISTORY OF SUBSTANCE ABUSE

AIDS/HIV

HAVE YOU BEEN EXPOSED TO AIDS?
HAVE YOU USED ANY SELF PROCURE
INJECTABLE DRUGS?
WHEN? _____
RESULTS? _____