Holland Hospital
PHYSICIAN OFFICES

# Systems Review

Name: Date of birth: Date:

As you review the following, please check any of those problems which apply to you:

| GENERAL | NOSE | KIDNEY/URINE/BLADDER |
|---|---|---|
| ☐ Recent weight gain – amount: ☐ | ☐ Nosebleeds | ☐ Pain or burning on urination |
| ☐ Recent weight loss – amount: ☐ | ☐ Nasal congestion | ☐ Blood in urine |
| ☐ Fatigue | ☐ Dryness | BLOOD |
| ☐ Fever | ☐ Nasal ulcers | ☐ Anemia |
| ☐ Night sweats | PSYCHIATRIC | ☐ Bleeding tendency |
| ☐ Sleep disturbances | ☐ Depression | ☐ Blood clots/ phlebitis |
| NERVOUS SYSTEM | ☐ Anxiety | ☐ Low platelet count |
| ☐ Headache | ☐ Other | SKIN |
| ☐ Dizziness | HEART & LUNGS | ☐ Easy bruising |
| ☐ Fainting | ☐ Pain in chest | ☐ Redness |
| ☐ Muscle spasm | ☐ Irregular heartbeat | ☐ Rash |
| ☐ Numbness or tingling sensation | ☐ Sudden change in heartbeat | ☐ Hives |
| ☐ Memory loss | ☐ Shortness of breath | ☐ Sun sensitive (sun allergy) |
| ☐ Seizure | ☐ Difficulty in breathing at night | ☐ Tightness |
| ☐ Tremors | ☐ Swollen legs or feet | ☐ Nodules/bumps |
| EARS | ☐ High blood pressure | ☐ Hair loss |
| ☐ Hearing loss | ☐ Heart murmurs | ☐ Color changes of hands/ feet in the cold |
| ☐ Ear drainage | ☐ Cough | ☐ Tick bite in the last 5 years |
| ☐ Ringing of ears/tinnitis | ☐ Coughing of blood | MUSCLES/JOINTS/BONES |
| EYES | ☐ Wheezing | ☐ Morning stiffness lasting how long? |
| ☐ Pain | ☐ Pleurisy | ☐ Joint pain |
| ☐ Redness | STOMACH AND INTESTINES | ☐ Muscle weakness |
| ☐ Dryness | ☐ Nausea | ☐ Muscle tenderness |
| ☐ Vision loss | ☐ Increasing constipation | ☐ Joint swelling – |
| ☐ Double vision | ☐ Persistent diarrhea | List joint affected in the last 6 mo.: |
| ☐ Light sensitivity | ☐ Blood in stools | 1. |
| MOUTH | ☐ Heartburn | 2. |
| ☐ Mouth sores | ☐ Ulcers | 3. |
| ☐ Dry mouth | ☐ Acid reflux | 4. |
| ☐ Hoarseness | ☐ Vomiting | 5. |
| ☐ Swollen glands | | |
| ☐ Other: | | |

**To assist us in meeting your needs today, please answer the following questions.**

**Name: _____ DOB: _____ Date: _____**

**Since my last visit, I'm doing:** ☐ Very Well ☐ Well ☐ Fair ☐ Poor ☐ Very Poor

**Compared to my last visit here, I'm doing:** ☐Same ☐ Better ☐Worse

**What bothers you most today?** _____

_____

**On a scale of 0-10, with 0 being no pain and 10 being extreme pain, how much pain are you in?**

0☐ 1☐ 2☐ 3☐ 4☐ 5☐ 6☐ 7☐ 8☐ 9☐ 10☐

**How long is your morning stiffness? (check the box)**

☐ None ☐<10min ☐15min ☐30min ☐45min ☐1hr ☐2hr ☐4hr ☐All day

**Describe your night-time sleep: (check the box)**

☐ Great ☐ Normal ☐ Fair ☐ Poor ☐ Very Poor ☐ Can't Fall Asleep

☐ Can't Stay Asleep ☐ Wake Early ☐ Snoring ☐ Restless Legs ☐ Night Pain

**Since last visit, I've had:**

☐ No Problems

☐ Falls / Injuries _____

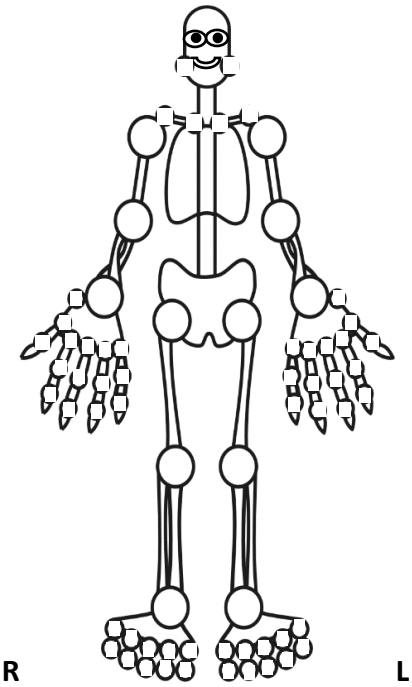
☐ New Diagnosis _____

☐ Infection _____

☐ Surgery _____

☐ Hospitalization _____

**Please check the areas below that are bothering you most today.**



**R** **L**

If you are on Hydroxychloroquine (Plaquenil), when was your last Hydroxychloroquine specific Eye Exam? _____ Where was it completed? _____