

## Systems Review

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

Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

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

Please check the areas below that are bothering 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)

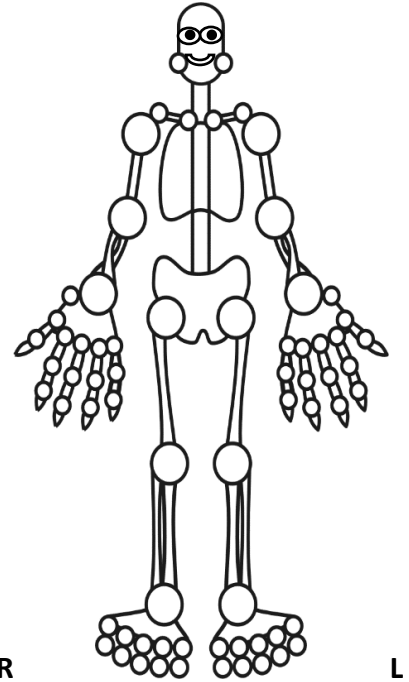
None    <10min    15min    30min    45min    1hr    2hr    4hr    All day

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 \_\_\_\_\_



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