

Systems Review Checklist

NAME: _____ DATE: _____

SYSTEMS REVIEW:

Put a check mark next to any symptoms/conditions that you have.

General: Fever Weight Loss Fatigue
 Chills Weight Gain Trouble Sleeping

Head: Glaucoma Hearing Problems Cataracts Sinus Problems

Cardiovascular: High Blood Pressure Heart Murmur Arrhythmia
 Heart Disease Palpitations Chest Pain

Respiratory Cough Pneumonia Bronchitis Shortness of Breath Asthma

Gastrointestinal: Nausea/Vomiting Ulcers Colitis Change In Bowel Habits Blood in Stool
 Black Stool Trouble Swallowing Hiatal Hernia Loss of Appetite
 Stomach Pain Hemorrhoids Hepatitis Constipation/Diarrhea

Genitourinary: Painful/Burning On Urination Prostate Problems Loss of Bladder Control
 Blood in Urine Kidney Stones Kidney Problems Trouble Starting
 Stopping Stream

OB/GYN: Regular Menses: Yes No Pregnancies _____ Live Births _____
 Last Menstrual Period _____ Last Pap Smear: _____

Musculoskeletal: Leg Pains Arthritis Joint Pains Gout Back Pain Ankle Swelling

Hematologic/Oncologic: Cancer Clotting Anemia Bleeding Phlebitis

Endocrine: Diabetes Thyroid

Skin/Breast: Hair Loss Rash Breast Lump Nipple Discharge Last Mammogram _____

Neurologic: Headache Stroke Seizures Dizziness Blackouts/Fainting Weakness in arms/legs

Psychiatric: Depression Anxiety Chemical Dependency Treatment By Psychiatrist or Psychologist

FAMILY HISTORY:

Is there any history of the following diseases in your family? If yes, indicate which relative.

Disease	Which Relative	Disease	Which Relative	Disease	Which Relative
Cancer		Heart Disease		Stroke	
High Blood Pressure		Bleeding Tendency		Reaction to Anesthesia	
Blood Clots		Diabetes		Allergies	
Asthma		Depression		Other	