

Systems Review

Please check any of the following you have experienced in the last year:

1. General:

- | | |
|--|---|
| <input type="checkbox"/> Weight gain | <input type="checkbox"/> Change in energy level |
| <input type="checkbox"/> Weight loss | <input type="checkbox"/> Night sweats |
| <input type="checkbox"/> Fevers | <input type="checkbox"/> Chills |
| <input type="checkbox"/> Excessive fatigue | |

2. Endocrine:

- | | |
|--|--|
| <input type="checkbox"/> Feeling of excessive warmth or coldness | <input type="checkbox"/> Feeling of excessive thirst or excessive hunger |
| <input type="checkbox"/> Change in the amount you urinate | |

3. Blood and lymphatic:

- | | |
|--|---|
| <input type="checkbox"/> Easy bruising | <input type="checkbox"/> Enlarged lymph nodes |
| <input type="checkbox"/> Prolonged or excessive bleeding | <input type="checkbox"/> Enlarged tonsils |
| <input type="checkbox"/> Blood clots in your legs | |

4. Mental health:

- | | |
|---|---|
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Undue sadness or depression | <input type="checkbox"/> Trouble with your sleep |
| <input type="checkbox"/> Thoughts of harming yourself or others | <input type="checkbox"/> Thoughts of ending your life |

5. Skin:

- | | |
|---|--|
| <input type="checkbox"/> Change in the texture or amount of your hair | <input type="checkbox"/> Changes in your skin or nails |
| <input type="checkbox"/> New rashes | <input type="checkbox"/> Lumps |
| <input type="checkbox"/> Sores or changes in any moles | |

6. Eyes:

- | | |
|--|--|
| <input type="checkbox"/> Changes in vision | <input type="checkbox"/> Blurry vision |
| <input type="checkbox"/> Double vision | <input type="checkbox"/> Red or painful eyes |

7. Ears:

- | | |
|---|---|
| <input type="checkbox"/> Changes in hearing | <input type="checkbox"/> Pain or drainage from ears |
| <input type="checkbox"/> Ringing in your ears | <input type="checkbox"/> Dizziness with or without changes in head position |

8. Nose and sinuses:

- | | |
|---|-------------------------------------|
| <input type="checkbox"/> Increase in frequency of colds or nasal drainage | <input type="checkbox"/> Nosebleeds |
| <input type="checkbox"/> Sinus infections | <input type="checkbox"/> Allergies |

9. Mouth, throat and teeth:

- | | |
|--|--|
| <input type="checkbox"/> Tongue or mouth sores | <input type="checkbox"/> Recent dental work |
| <input type="checkbox"/> Hoarseness or voice changes | <input type="checkbox"/> Problems swallowing |
| <input type="checkbox"/> Bleeding of gums | |

10. Neck:

- | | |
|--------------------------------|-----------------------------------|
| <input type="checkbox"/> Lumps | <input type="checkbox"/> Swelling |
| <input type="checkbox"/> Pain | |

11. Breasts/Chest:

- | | | |
|---|--|--------------------|
| <input type="checkbox"/> Tenderness | <input type="checkbox"/> Lumps | |
| <input type="checkbox"/> Nipple discharge | <input type="checkbox"/> Milk production | (please turn over) |

12. Respiratory:

- New cough
- Wheezing or shortness of breath
- Coughing blood
- Pain with breathing

13. Cardiac:

- Chest pain
- Palpitations/Unusual heart beat
- Swelling in your ankles
- Fainting or passing out spells
- Pressure or unusual feeling in chest
- Shortness of breath with activity
- Shortness of breath lying down

14. Blood vessels:

- Pain in your legs with walking
- Varicose veins
- Sensitivity or change in color of your fingers or toes with cold temperatures

15. Gastrointestinal:

- Changes in your appetite
- Trouble swallowing
- Nausea
- Vomiting
- Vomiting blood
- Abdominal pain
- Indigestion or constipation
- Diarrhea
- Recent change in frequency, consistency, color or appearance of stool
- Blood in stool
- Black, tarry appearance of stool

16. Urinary:

- Change in frequency of urination
- Burning on urination
- Hesitancy
- Change in volume of urine or stream
- Blood in urine
- Urgency or incontinence (loss of control of urine)

17. Male genitoreproductive:

- Sores on penis
- Difficulties with erection
- Pain or masses in testicles

18. Female genitoreproductive:

- Changes in duration, amount or frequency of menses
- Hot flashes
- Painful sexual intercourse
- Lack of sexual desire
- Vaginal dryness
- Vulvar itching

19. Musculoskeletal:

- Muscle weakness
- Tenderness
- Pain or swelling in any joints
- Muscle pain
- Stiffness

20. Neurologic:

- Headaches
- Numbness or tingling of hands or feet
- Difficulty speaking
- Abnormal movements
- Recent falls
- Blackouts or near blackouts
- Chronic pain
- Memory loss or difficulty concentrating
- Weakness
- Problems with balance