SYSTEMIC REVIEW

Do you have any of the following? (Please circle No or Yes or ask for assistance.)

General:

- Good general health most of your life? No Yes
- Living Will / Advanced Directives?.......... No Yes
- Recent weight change?........................... No Yes
- Weight loss desired?................................... No Yes

Skin:

- Varicose Veins?... No Yes
- Raised moles?... No Yes
- Abnormal pigmentation / color?............. No Yes
- Rash, hives or eczema?............................. No Yes
- Skin disease?... No Yes
- Jaundice?... No Yes

Head-Eyes-Ears-Nose-Throat:

- Glasses / Contact Lenses / Poor Vision? No Yes
- Eye disease / injury / problems?................ No Yes
- Glaucoma?.. No Yes
- Recurrent headaches?............................. No Yes
- History of unconsciousness/ concusiions? No Yes
- Ear disease / impaired hearing?.............. No Yes
- Chronic dizziness?....................................... No Yes
- Chronic sinus problems?............................ No Yes
- Recurrent nose bleeds?............................. No Yes
- Enlarged glands?.. No Yes

Respiratory / Chest:

- Cold / Upper respiratory infection now?. No Yes
- Spitting up blood?....................................... No Yes
- Chronic or frequent cough?...................... No Yes
- History of asthma, wheezing or tuberculosis? No Yes
- Difficulty breathing?..................................... No Yes
- History of lung problems &/or pneumonia? No Yes
- Breast disease or masses?........................... No Yes
- Last Mammogram Normal (When)?.......... No Yes

Cardiovascular:

- Chest pain or angina pectoris?................. No Yes
- Shortness of breath while lying or walking? No Yes
- Heart trouble or history of heart attacks? No Yes
- High blood pressure or hypertension?........ No Yes
- Swelling of hands, feet or ankles?.............. No Yes
- Heart murmur?... No Yes

Gastrointestinal (GI):

- Vomiting blood?.. No Yes
- Peptic, stomach or duodenal ulcer?........ No Yes
- Chronic heartburn or indigestion?............ No Yes
- Cramping or pain in the abdomen?......... No Yes
- Gallbladder disease?................................. No Yes
- History of liver disease or hepatitis?........... No Yes
- History of intestinal disease?....................... No Yes
- Bleeding with bowel movements?........... No Yes
- Black tarry stools / bowel movements?. No Yes
- Hemorrhoids or piles?.................................. No Yes

Genitourinary (GU):

- Loss of urine / incontinence?..................... No Yes
- Frequent night time urinating?.................. No Yes
- Burning or painful urination?...................... No Yes
- Blood in urine or kidney stones?................ No Yes
- History of any kidney disease?.................. No Yes

Hematologic:

- Any blood disease?.. No Yes
- History of anemia?.. No Yes
- Slow to heal cuts, or easy to bleed / bruise?.............. No Yes
- History of blood transfusions?.. No Yes

Neuro-Psychiatric:

- History of or need for psychiatric care?........................ No Yes
- Suicidal Ideas?... No Yes
- History of excessive alcohol use /alcoholism?............. No Yes
- History of convulsions, epilepsy or paralysis?............... No Yes

Endocrine / Other:

- Diabetes type 1, 2 or during pregnancy?.................... No Yes
- Thyroid Problems?.. No Yes
- Change in hair growth / distribution?........................... No Yes
- Have you become colder or your skin dryer?............. No Yes
- Arthritis or any rheumatologic disease?........................ No Yes
- History of cancer or precancerous disease?................ No Yes

GYNECOLOGIC:

- Age periods started____
- #Days between periods____
- #Days periods last____
- First Day Last Menstrual Period______________________________________
- When was last Pap smear?____
- Last Pap smear was normoal?...................................... No Yes
- Are your periods regular?... No Yes
- Any pain with your periods?.. No Yes
- Are you sexually active?.. No Yes
- Any pain with sex?.. No Yes
- Any vaginal discharge or itching?................................ No Yes
- Current HIV infection?... No Yes
- Past Gonorrhea or Chlamydia?.................................... No Yes
- Past Trichomoniasis (Trich)?.. No Yes
- Past genital warts or Condyloma?................................ No Yes
- Past HPV or genital herpes?.. No Yes
- Any other past STDs or VD?.. No Yes
- Are you using contraception?....................................... No Yes
  - If so, what type / name? ______________________________________

OBSTETRICS:

- Number of total pregnancies______________________________________
- Number of total births____
- Number of miscarriages &/ or abortions______________________________
- Number of children alive____

------------------fill in the data below regarding your births----------------

Mo/Yr	Preterm?	Vaginal?	Weight	Sex	Complications
1)					
2)					
3)					
4)					
5)					

ANYTHING ELSE YOU WANT TO ADD?................................. No Yes

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Patient will update doctor as need be?........................... No Yes

Print patient's name ____

Todays date ____

Patient's signature(guardian?) X_____________________________________

Dr. Taras' signature ____