TEMESCAL CREEK MEDICINE

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REVIEW OF SYSTEMS: ADULT

PATIENT NAME: _____ **DATE:** _____

Please take a moment to complete the following. In the last **3 months** have you experienced any of the following? Please indicate **YES** or **NO** and **explain** if appropriate.

GENERAL	**Yes**	**No**	**If YES, please explain further:**
	☐	☐	Recurrent fever or chills?
	☐	☐	Unintentional weight loss?
	☐	☐	Recurrent fatigue or malaise?
NEUROLOGIC	**Yes**	**No**	
	☐	☐	Frequent dizziness?
	☐	☐	Fainting?
	☐	☐	Weakness in arms or legs?
	☐	☐	Numbness or tingling in arms or legs?
	☐	☐	Un-coordination or loss of balance?
CARDIAC	**Yes**	**No**	**Do you have:**
	☐	☐	Chest pain or pressure?
	☐	☐	Shortness of breath with normal activity?
	☐	☐	Difficulty breathing when lying flat?
	☐	☐	Shortness of breath that wakes you from sleep?
	☐	☐	Palpitations (sensation of heart beating in your chest)?
	☐	☐	Swelling in the ankles?
SKIN	**Yes**	**No**	
	☐	☐	Rash ?
	☐	☐	New skin lesions, lumps or bumps?
	☐	☐	Jaundice (yellowing of the skin or eyes)?
	☐	☐	Moles that are changing color or size?
HEENT	**Yes**	**No**	
	☐	☐	Headaches that are new or changing in frequency or severity?
	☐	☐	Hearing changes?
	☐	☐	Visual changes? (if yes, are you seeing an eye doctor?)
	☐	☐	Non-healing mouth sores?
	☐	☐	Swollen glands or neck lumps?
	☐	☐	Hoarseness?
RESPIRATORY	**Yes**	**No**	
	☐	☐	Cough that is ongoing, produces phlegm or is changing?
	☐	☐	Difficulty breathing?
	☐	☐	Wheezing?
	☐	☐	Do you smoke or are you exposed to 2nd hand smoke?
GASTROINTESTINAL	**Yes**	**No**	
	☐	☐	Heart Burn or Acid Reflux?
	☐	☐	Difficult or painful swallowing?
	☐	☐	Recurrent nausea or vomiting?
	☐	☐	Recurrent diarrhea or constipation?
	☐	☐	Recurrent abdominal pain or cramping?
	☐	☐	Bloody or black bowel movements?

PLEASE TURN OVER AND COMPLETE OTHER SIDE

Please take a moment to complete the following. In the last **3 months** have you experienced any of the following? Please indicate **YES** or **NO** and **explain** if appropriate.

GENITOURINARY	**Yes**	**No**	
	☐	☐	Pain with urination?
	☐	☐	Dark or reddish urine?
	☐	☐	Involuntary loss of urine?
(males)	☐	☐	Decreased force of urine stream or difficultly starting urine?
(males)	☐	☐	Problems achieving or maintaining erections?
MUSCULOSKELETAL	**Yes**	**No**	
	☐	☐	Painful joints? (If yes, which ones?)
	☐	☐	Swollen joints?
	☐	☐	Morning joint stiffness? (If yes, how long does the stiffness last?)
PSYCHOLOGICAL	**Yes**	**No**	
Read Carefully →	☐	☐	Do you feel safe at home?
	☐	☐	Anxiety?
	☐	☐	Little interest or pleasure in doing things?
	☐	☐	Feeling Down, Depressed or Hopeless?
	☐	☐	Suicidal thoughts?
	☐	☐	Social problems that you feel interfere with your mental or physical health?
If you use alcohol or other recreational drugs			
	☐	☐	Have you ever tried to cut down or change your use?
	☐	☐	Have you ever been angered or annoyed by people confronting your use?
	☐	☐	Have you ever felt guilty about your use or consequences of your use?
	☐	☐	Have you ever used first thing in the morning as an “eye opener”?
INFECTIONS	**Yes**	**No**	
	☐	☐	Do you feel you are at risk for HIV infection?
	☐	☐	Have you ever been exposed to or treated for tuberculosis?
	☐	☐	Have you ever had a blood transfusion?
	☐	☐	Recurrent night sweats?
	☐	☐	Sexually transmitted diseases?
ENDOCRINE	**Yes**	**No**	
	☐	☐	Frequent urination? (If yes, how many times do you get up at night to urinate?)
	☐	☐	Increased thirst?
	☐	☐	Skin, hair or fingernail changes?
	☐	☐	Hot or cold intolerance?
GYNECOLOGIC	**Yes**	**No**	(FEMALE Patients)
	☐	☐	Have you ever had a menstrual period?
	☐	☐	Painful or heavy menstrual periods?
	☐	☐	Are you still having menstrual periods? If YES, when was your last menstrual period? _____ If NO, at what age did your periods stop? _____
	☐	☐	Vaginal bleeding differing from you regular menstrual flow?
	☐	☐	Abnormal Vaginal discharge?
	☐	☐	Painful intercourse?
	☐	☐	New breast lumps?