

Systems Review

Below are a list of diseases which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of care.

CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:

- | | | | |
|--|--|---|--------------------------------------|
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Mumps | <input type="checkbox"/> Influenza INTAKE | |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Small Pox | <input type="checkbox"/> Pleurisy | <input type="checkbox"/> Coffee |
| <input type="checkbox"/> Polio | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Tea |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Alcohol |
| <input type="checkbox"/> Whooping Cough | <input type="checkbox"/> Cancer | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Cigarettes |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Lumbago | <input type="checkbox"/> White Sugar |
| <input type="checkbox"/> Measles | <input type="checkbox"/> Thyroid | <input type="checkbox"/> Eczema | |

Have you been tested HIV positive? YES No

CHECK ANY OF THE FOLLOWING YOU HAVE HAD THE PAST 6 MONTHS:

MUSCULO-SKELETAL CODE

FEMALES ONLY: When was your last period? _____

- | | |
|---|---|
| <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Gas/Bloating After Meals |
| <input type="checkbox"/> Pain Between Shoulders | <input type="checkbox"/> Heartburn |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Black/Bloody Stool Are you pregnant? |
| <input type="checkbox"/> Arm Pain | <input type="checkbox"/> Colitis <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Not Sure |
| <input type="checkbox"/> Joint Pain/Stiffness | |
| <input type="checkbox"/> Walking Problems | |
| <input type="checkbox"/> Difficult Chewing/Clicking Jaw | |
| <input type="checkbox"/> General Stiffness | |
| <input type="checkbox"/> Discolored Urine | |

GENITO-URINARY CODE

- | |
|--|
| <input type="checkbox"/> Bladder Trouble |
| <input type="checkbox"/> Painful/Excessive Urination |

NERVOUS SYSTEM CODE C-V-R CODE

- | | |
|--|---|
| <input type="checkbox"/> Nervous | <input type="checkbox"/> Chest Pain |
| <input type="checkbox"/> Numbness | <input type="checkbox"/> Short Breath |
| <input type="checkbox"/> Paralysis | <input type="checkbox"/> Blood Pressure Problems |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Irregular Heartbeat |
| <input type="checkbox"/> Forgetfulness | <input type="checkbox"/> Heart Problems |
| <input type="checkbox"/> Confusion/Depression | <input type="checkbox"/> Lung Problems/Congestion |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Varicose Veins |
| <input type="checkbox"/> Convulsions | <input type="checkbox"/> Ankle Swelling |
| <input type="checkbox"/> Cold/Tingling Extremities | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Stress | |

GENERAL CODE EENT CODE

- | | |
|--|---|
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Vision Problems |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Dental Problems |
| <input type="checkbox"/> Loss of Sleep | <input type="checkbox"/> Sore Throat |
| <input type="checkbox"/> Fever | <input type="checkbox"/> Ear Aches |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Hearing Difficulty |
| <input type="checkbox"/> Stuffed Nose | |

Please outline on the diagram the area of your discomfort

GASTRO-INTESTINAL CODE MALE/FEMALE CODE FAMILY HISTORY

- | | |
|--|--|
| <input type="checkbox"/> Poor/Excessive Appetite | <input type="checkbox"/> Menstrual Irregularity |
| <input type="checkbox"/> Excessive Thirst | <input type="checkbox"/> Menstrual Cramps |
| <input type="checkbox"/> Frequent Nausea | <input type="checkbox"/> Vaginal Pain/Infection |
| <input type="checkbox"/> Vomiting | <input type="checkbox"/> Breast Pain/Lumps |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Prostate/Sexual Dysfunction |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Other Problems |
| <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Liver Problems | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Gall Bladder Problems | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Weight Trouble | |
| <input type="checkbox"/> Abdominal Cramps | |

The following members have a same or similar problem as I do:

- | |
|----------------------------------|
| <input type="checkbox"/> Mother |
| <input type="checkbox"/> Father |
| <input type="checkbox"/> Brother |
| <input type="checkbox"/> Sister |
| <input type="checkbox"/> Spouse |
| <input type="checkbox"/> Child |