SYSTEM REVIEW Patient Name_____

Check (√) Appropriate Box – Please check each box				Use this space for continuation of Present Illness and/or to Describe Symptoms
Yes	No	Unsure		
			Chills	
			Fever	
			Weight Change	
			Eyes:	
			Eye Pain	
			Loss of Vision	
			Double Vision	
			ENT:	
			Ear Pain	
			Deafness	
			Bleeding Nose	
			Hoarseness	
			Difficulty Swallowing	
			Cardiorespiratory:	
			Cough	
			Sputum	
			Blood with Coughing	
			Leg Swelling	
			Gastrointestinal:	
			Poor appetite	
			Nausea & Vomiting	
			Constipation	
			Diarrhea	
			Change in Bowel Habits	
			Jaundice	
			Abdominal Pain	
			Anal Bleeding	
			Anal Pain	
			Genitourinary:	
			Frequency	
			Urgency	
			Blood in Urine	
			Stones or Gravel	
			Urethral Discharge	
			Incontinence	
			Neuropsychiatric:	
			Headaches	
			Seizures	
			Paralysis	
			Anxiety	
			Depression	
			Disturbance of Gait or Speech	
			Disturbing Feelings or Thoughts	
			Musculoskeletal:	
			Back Pain	
			Bone Infection(s)	
			Skeletal Deformities	
			Joint Pain or Swelling	
			Vericose Veins	
			Leg Ulcers	
			OB/GYN:	
			Number of Pregnancies	#_____
			Number of Vaginal Deliveries	#_____
			Non-Menstrual Bleeding	
			Excessive Menstrual Flow	
			Irregular Menstrual Flow	
			Pelvic Pain	

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Carolyn E. Jones, M.D. Date