

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

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