code: GF004

Sunny Hills Medical Center
Urgent Care . Primary Care
Behavioral Health

REVIEW OF SYSTEMS

First Name **Middle Initial** **Last Name**

Check the box if you are **currently** experiencing any of the following:

General

- ☐ Arthritis/Rheumatism
- ☐ Back Pain (recurrent)
- ☐ Bone Fracture
- ☐ Cancer
- ☐ Diabetes
- ☐ Foot Pain
- ☐ Gout
- ☐ Headaches/Migraines
- ☐ Joint Injury
- ☐ Memory Loss
- ☐ Muscle Weakness
- ☐ Numbness/Tingling
- ☐ Obesity
- ☐ Osteoporosis
- ☐ Rheumatic Fever
- ☐ Weight Gain/Loss
- ☐ None

Skin

- ☐ Abnormal Pigmentation
- ☐ Boils
- ☐ Brittle Nails
- ☐ Dry Skin
- ☐ Eczema
- ☐ Frequent infections
- ☐ Hair/Nail changes
- ☐ Hives
- ☐ Itching
- ☐ Jaundice
- ☐ Psoriasis
- ☐ Rash
- ☐ Skin Disease
- ☐ None

Respiratory

- ☐ Any Lung Troubles
- ☐ Asthma or Wheezing
- ☐ Bronchitis
- ☐ Chronic or Frequent Cough
- ☐ Difficulty Breathing
- ☐ Pleurisy or Pneumonia
- ☐ Spitting up Blood
- ☐ Trouble Breathing
- ☐ URI (Cold) Now
- ☐ None

Cardiovascular

- [ ] Awakening in the night smothering
- [ ] Chest Pain or Angina
- [ ] Congestive Heart Failure
- [ ] Cyanosis (blue skin)
- [ ] Difficulty walking two blocks
- [ ] Edema/Swelling of Hands, Feet or Ankles
- [ ] Heart Attacks
- [ ] Heart Murmur
- [ ] Heart Trouble
- [ ] High Blood Pressure
- [ ] Irregular Heartbeat
- [ ] Pain in legs
- [ ] Palpitations
- [ ] Poor Circulation
- [ ] Shortness of Breath
- [ ] Varicose Veins/Phlebitis
- [ ] None

Gastrointestinal

- [ ] Abdominal Pain
- [ ] Appetite Changes
- [ ] Black Stools
- [ ] Bleeding with Bowel Movements
- [ ] Blood in Vomit
- [ ] Chrohn's Disease/Colitis
- [ ] Constipation
- [ ] Cramping or pain in the Abdomen
- [ ] Difficulty Swallowing
- [ ] Diverticulosis
- [ ] Frequent Diarrhea
- [ ] Gallbladder Disease
- [ ] Gas/Bloating
- [ ] Heartburn or Indigestion
- [ ] Hemorrhoids or Piles
- [ ] Hepatitis
- [ ] Hernia
- [ ] Liver Trouble
- [ ] Nausea/Vomiting
- [ ] Painful Bowel Movements
- [ ] Peptic Ulcer (Stomach or Duodenal)
- [ ] Recent change in Bowel habits

Eyes - Ears - Nose - Throat/Mouth

- [ ] Blurring
- [ ] Double Vision
- [ ] Eye Disease or Injury
- [ ] Eye Pain/Discharge
- [ ] Glasses
- [ ] Glaucoma
- [ ] Itchy Eyes
- [ ] Vision changes
- [ ] Ear Disease
- [ ] Ear Infections
- [ ] Ears ringing
- [ ] Hearing problems
- [ ] Impaired Hearing
- [ ] Chronic Sinus Trouble
- [ ] Itchy Nose
- [ ] Nosebleeds
- [ ] Postnasal drip
- [ ] Sinusitis
- [ ] Sneezing or Runny Nose
- [ ] Gum Bleeding
- [ ] Hoarseness
- [ ] Loss of Taste
- [ ] Mononucleosis
- [ ] Sore Throat
- [ ] Sores
- [ ] None

Genitourinary

- [ ] Blood in Urine
- [ ] Bright's Disease
- [ ] Burning or painful Urination
- [ ] Decrease in force/flow
- [ ] Frequent Urination
- [ ] Incontinence
- [ ] Kidney Stones
- [ ] Kidney Trouble
- [ ] Night time Urinating
- [ ] Prostate Problems
- [ ] None

Hematologic

- [ ] Abnormal Bruising or Bleeding
- [ ] Anemia
- [ ] Blood Disease
- [ ] Excessive Bleeding after tooth extraction
- [ ] Phlebitis
- [ ] Slow to heal
- [ ] None

Endocrine

- [ ] Become colder than before
- [ ] Changes in Hair Growth
- [ ] Changes in hat or glove size
- [ ] Fatigue Sweating/Night Sweats
- [ ] Fever/Chills
- [ ] Frequent infections
- [ ] Goiter
- [ ] Heat/cold intolerance
- [ ] Hormone Therapy
- [ ] Lymph node Enlargement
- [ ] Sleep Problems
- [ ] Thyroid Disease
- [ ] Weakness/Paralysis
- [ ] Weight Change
- [ ] None

Neurological

- [ ] Convulsions/Seizures
- [ ] Dizziness
- [ ] Fainting Spells
- [ ] Gait/Coordination
- [ ] Headaches/Migraines
- [ ] Paralysis
- [ ] Psychiatric Care
- [ ] Stroke
- [ ] Trauma
- [ ] Tremor/Hand Shaking
- [ ] None

Mental Health

Have you ever been diagnosed or treated for Depression and/or Anxiety?

- ( ) Yes
- ( ) No

Have you ever been diagnosed or treated for an Eating Disorder (e.g. anorexia/bulimia)?

- ( ) Yes
- ( ) No

Do you panic when stressed?

- ( ) Yes
- ( ) No

Do you have a problem with your appetite when under stress?

- Yes
- No

Do you cry frequently?

- Yes
- No

Have you ever attempted suicide?

- Yes
- No

Have you ever seriously thought about hurting yourself?

- Yes
- No

Do you have trouble sleeping?

- Yes
- No

Have you ever been to a counselor?

- Yes
- No

Have you been diagnosed or treated for Bi-Polar disorder?

- Yes
- No

Men Only

Do you usually get up to urinate during the night?

- Yes
- No

Any loss of libido or sex drive?

- Yes
- No

Any blood in your urine?

- Yes
- No

Have you had any kidney, bladder, or prostate infections within the last 12 months?

- Yes
- No

Any difficulty with erection or ejaculation?

- Yes
- No

Women Only

Heavy periods, irregularity, spotting, pain, or discharge?

- Yes
- No

Are you pregnant or breastfeeding?

- Yes
- No

Any hot flashes or sweating at night?

- Yes
- No

Do you have menstrual tension, bloating, irritability, or other symptoms at or around time of period?

- Yes
- No

Recurrent vaginal infections?

- Yes
- No

Pain/bleeding with sex?

- Yes
- No

Age at onset of menstruation:

_____

Number of pregnancies:

_____

Number of live births:

_____

Number of miscarriages:

_____

Number of abortions:

_____

Date of last menstruation:

_____

Length of cycle:

_____

Days of flow:

_____

Birth control method?

Date of last PAP

Date of last Mammogram

All Patients

Is there anything that hasn't been covered above that you would like to add or explain?

My signature indicates the above information is correct.

Signature of Patient (or Guardian/Authorized Representative):
Full Name of above signed (if not patient)

Date:

This information will assist us in assessing your particular problem areas and establishing your medical management. Thank you for your time and patience in completing this form.