

ANNUAL EXAM SYSTEM REVIEW		Name:	DOB:	Date:	
NOTE TO THE PATIENT: Please review each question/item below and check any items that apply to you. Please circle yes (Y) <i>identifying which items are NEW or DIFFERENT</i> . If you have any special or specific concerns , please list them here :					
System and Problem	Circle if YES	How Long?	System and Problem	Circle if YES	How Long?
1-General:			8-Female genital:		
Fevers or chills	Y		Last menstrual period: _____	Y	
Night sweats	Y		Recent irregular or change in periods	Y	
Weight loss [Unexpected]	Y		Vaginal irritation, burning or discharge	Y	
Weight gain [Unexpected]	Y		Unexpected menstrual bleeding	Y	
Excessive fatigue	Y		Painful periods	Y	
Excessive daytime sleepiness	Y		9-Musculoskeletal:		
Loss of or poor appetite	Y		Joint aches or pains	Y	
Poor Sleep (falling or staying)	Y		Joint swelling or stiffness	Y	
2-ENT			Decreased joint range of motion	Y	
Dramatic changes in vision	Y		Bone pain	Y	
Tinnitus/ringing in ears	Y		10-Skin and Breasts:		
Hearing loss	Y		Nipple discharge	Y	
Nose bleeds	Y		Non-healing sores	Y	
Sinus pressure/pain or Ear pain	Y		Concerning moles, lumps, or growths	Y	
Sore throat	Y		Breast Lump[s]	Y	
Hoarseness more than 2 weeks	Y		Concerning rash	Y	
3-Cardiovascular:			Breast pain or tenderness	Y	
Chest pain or pressure w/ exertion	Y		11-Lymphatic/Hematologic		
Unusual shortness of breath	Y		Swollen glands @ neck, armpit, groin	Y	
Palpitations	Y		Bruising concerns	Y	
Swelling of extremities[edema]	Y		12-Neurologic:		
Calf pain when walking	Y		New or more severe Headaches	Y	
4-Respiratory:			Fainting or lightheadedness	Y	
Persistent coughing or wheezing	Y		Memory problems	Y	
Blood tinged sputum	Y		Numbness or tingling (in hands or feet, etc)	Y	
Pain with deep breathing	Y		New balance problems	Y	
5-Gastrointestinal:			Muscle weakness	Y	
Frequent heartburn	Y			Y	
Pain or difficulty swallowing [dysphagia]	Y		13-Psychiatric:		
Change in bowel habits	Y		Feeling sad, blue, irritable, angry	Y	
Nausea or vomiting	Y		Loss of sex drive	Y	
Increased constipation	Y		Suicidal thoughts	Y	
Frequent diarrhea or mucous	Y		Feeling anxious	Y	
Blood in stool or on toilet paper	Y		Preoccupations or compulsions	Y	
Black, tarry stools	Y		Loss of ambition or motivation	Y	
Indigestion or bloating problems	Y		Decrease or loss of interest in hobbies	Y	
Abdominal pain	Y		14-Allergy and Immunologic:		
6-Urinary Tract:			Hay fever	Y	
Burning or urgency of urination	Y		Itchy, watery eyes or nose	Y	
Increased urinary frequency	Y		Itchy or sensitive skin	Y	
Difficulty controlling urination	Y		Persistent clear nasal/postnasal drainage	Y	
Blood in urine (or change in color)	Y		Excessive or frequent infections	Y	
7-Male genital:			15-Endocrine:		
Testicle or scrotal lumps/discomfort	Y		Markedly increased thirst	Y	
Erectile dysfunction	Y		Markedly increased urination	Y	
Changes in urinary	Y		Intolerance of Heat or cold	Y	

TSH ___ Chem 12 ___ CBC ___ Lipid ___

Patient signature: _____

PSA ___ Micro AL ___ UA ___ U/A&CS ___

Dated: _____

Testo ___ ESR ___ A1C ___ Vit D ___

Preferred Pharmacy: _____

Vit B 12 ___ Glucose ___ Uric Acid ___ Other ___