

SYSTEM REVIEW

Male

GENERAL

Do you eat a well balanced diet? _____ NO YES
 Approx. weight now _____ 1 yr ago _____
 Maximum weight _____
 Exercise? Frequency / Wk _____
 Activities _____
 Any Sexual Concerns? _____ NO YES
Year of Last Complete Physical _____
 Headaches _____ NO YES
 Glasses/contacts _____ NO YES
 Double vision _____ NO YES
 Eye disease or injury _____ NO YES
Year last checked for glaucoma _____
 Itching eyes or nose/hay fever _____ NO YES
 Septal deviation / polyps (circle) _____ NO YES
 Nosebleeds _____ NO YES
 Sinus trouble _____ NO YES
 Ear disease _____ NO YES
 Impaired hearing _____ NO YES
 Ringing in the ears _____ NO YES
 Hoarseness _____ NO YES

NECK

Stiffness _____ NO YES
 Enlarged glands _____ NO YES
 Injury _____ NO YES

RESPIRATORY

Coughing up blood _____ NO YES
 Chronic cough (including Smoker's Cough) _____ NO YES
 Wheezing _____ NO YES
 Shortness of breath _____ NO YES
 How many blocks can you walk without having to stop to catch your breath? _____
 Night sweats _____ NO YES
 Skin test for tuberculosis _____ NO YES
 If yes, year tested and results _____
 Year of last chest x-ray _____

CARDIOVASCULAR

Chest pain or angina pectoris _____ NO YES
 Shortness of breath when lying flat _____ NO YES
 Pain in legs on walking, relieved by rest _____ NO YES
 Varicose veins _____ NO YES
 Ankles often badly swollen _____ NO YES
 Heart murmur _____ NO YES
 Rapid, hard or skipped heart beats _____ NO YES
 Year of last EKG? _____
 Have you had a stress treadmill? Year _____ NO YES

GASTROINTESTINAL

Change in appetite _____ NO YES
 Heartburn or indigestion _____ NO YES
 Sour taste in throat or mouth _____ NO YES
 Intolerance to spicy foods, coffee or alcohol _____ NO YES
 Ever vomited blood? _____ NO YES
 Do foods stick in throat? _____ NO YES
 Gallbladder trouble/ intol. to greasy foods _____ NO YES
 Intolerance to milk products _____ NO YES
 Hiatal Hernia _____ NO YES
 Pancreatitis _____ NO YES
 Do you often vomit? _____ NO YES
 Crampy abdominal pain _____ NO YES
 Chronic constipation _____ NO YES
 Frequent diarrhea _____ NO YES
 Change in bowel habits _____ NO YES
 Bloody or black bowel movements _____ NO YES
 Hemorrhoids or piles _____ NO YES

GENITORURINARY

Loss of urine when cough or sneeze _____ NO YES
 Kidney or bladder infection (circle) _____ NO YES
 Burning or frequent urination (circle) _____ NO YES
 Feeling must go immediately? _____ NO YES
 Do you have to get up at night to urinate? # _____ NO YES
 Blood in urine _____ NO YES
 Kidney stones _____ NO YES
 Swelling of hands and feet _____ NO YES
 Difficulty starting urination? _____ NO YES
 Decrease in strength of stream _____ NO YES
 Penile Discharge _____ NO YES
Date of last prostate exam _____

MUSCULOSKELETAL

Significant Arthritis / Joint pain _____ NO YES
 Low back pain _____ NO YES
 Muscle weakness or tenderness _____ NO YES
 Difficulty walking _____ NO YES
 Fractures (list) _____ NO YES

SKIN

Skin disorders (list) _____ NO YES

NEUROLOGIC / PSYCHIATRIC

Numbness / paralysis (circle) _____ NO YES
 Fainting spells _____ NO YES
 Memory loss _____ NO YES
 Dizziness _____ NO YES
 Do you have trouble sleeping? _____ NO YES
 Are you often depressed? _____ NO YES
 Are you often anxious or nervous? _____ NO YES
 Do you ever wish you were dead and away from it all? _____ NO YES
 Do you often worry? _____ NO YES
 Have you ever been under psychiatric care? _____ NO YES

HEMATOLOGIC

Excessive bleeding or abnormal bruising _____ NO

ENDOCRINE

Crave large amounts of fluids _____ NO YES
 Intolerance to slightly warm rooms _____ NO YES
 Intolerance to slightly cool rooms _____ NO YES
 Change in textures of hair or skin _____ NO YES
 Change in voice (as an adult) _____ NO YES
 Hair loss _____ NO YES
 Diminished sex drive _____ NO YES
 Darkening of skin _____ NO YES

Did someone other than the patient help fill this out? NO

Patient Signature: _____

Reviewing Physician: _____