NAME

☐ F ☐ M **BIRTHDATE**

Red Bud Internal Medicine & Pediatrics
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CIRCLE NO OR YES FOR THOSE THAT APPLY

SYSTEMIC REVIEW: Do you have any of the following?

General: Maximum weight________ Minimum weight________

- Recent weight change? .... No Yes
- Have you been in good general health most of your life? .... No Yes
- Have you recently had?
  - ☐ Weakness ☐ Fever ☐ Chills ☐ Night Sweats
  - ☐ Fainting ☐ Problems Sleeping

Skin:
- Skin Disease .... No Yes
- Jaundice .... No Yes
- Hives, eczema or rash .... No Yes

Head-Eyes-Ears-Nose-Throat (cont'd):
- Dry eyes or mouth .... No Yes
- Bleeding Gums - Frequent or Constant .... No Yes
- Blurred Vision .... No Yes
- Date of Last Eye Exam ____________
- Sneezing or runny nose .... No Yes
- Nosebleeds - Frequent .... No Yes
- Chronic sinus trouble .... No Yes
- Ear disease .... No Yes
- Impaired hearing .... No Yes
- Dizziness or sensation of room spinning .... No Yes
- Frequent or severe headaches .... No Yes

Respiratory:
- Asthma or Wheezing .... No Yes
- Difficulty breathing .... No Yes
- Any trouble with lungs .... No Yes
- Pleurisy or Pneumonia .... No Yes
- Cough up Blood (ever) .... No Yes

Cardiovascular:
- Chest pain, pressure, or tightness .... No Yes
- Shortness of breath with walking or lying down .... No Yes
- Difficulty walking two blocks .... No Yes
- Palpitations .... No Yes
- Swelling of hands, feet or ankles .... No Yes
- Awakening in the nights smothering .... No Yes
- Heart murmur .... No Yes

Gastrointestinal:
- Vomiting blood or food .... No Yes
- Gallbladder disease .... No Yes
- Change in appetite .... No Yes
- Hepatitis/Jaundice .... No Yes
- Painful bowel movements .... No Yes
- Bleeding with bowel movements .... No Yes
- Black stools .... No Yes
- Hemorrhoids or piles .... No Yes
- Recent change in bowel habits .... No Yes
- Frequent diarrhea .... No Yes
- Heartburn or indigestion .... No Yes
- Cramping or pain in the abdomen .... No Yes
- Does food stick in throat .... No Yes

Endocrine:
- Hormone therapy .... No Yes
- Any change in hat or glove size .... No Yes
- Any change in hair growth .... No Yes
- Have you become colder than before - or skin become dryer .... No Yes

Neck:
- Stiffness .... No Yes
- Enlarged glands .... No Yes

Genitourinary:
- Loss of urine .... No Yes
- Blood in urine .... No Yes
- Frequent urination .... No Yes
- Burning or painfu .... No Yes
- Night time urinating .... No Yes
- Kidney trouble .... No Yes
- Problem stopping/starting flow of urine .... No Yes
- Testicular mass .... No Yes
- Testicular pain .... No Yes
- Prostate problem .... No Yes
- Sexual Dysfunction .... No Yes
- STD / AIDS Risk .... No Yes

Gynecological:
- First day of last period ____________
- Age periods started ____________
- How long do periods last? ________ Days
- Frequency of periods every ________ Days
- Pain with periods .... No Yes
- Number of pregnancies ____________
- Number of miscarriages ____________
- Date of last cancer smear and results ____________
- Breast Lump .... No Yes
- Abnormal Vaginal Discharge .... No Yes
- Breast Discharge .... No Yes
- Pain with intercourse .... No Yes
- Skin change of Breast .... No Yes
- Nipple retraction .... No Yes

Locomotor-Musculoskeletal:
- Stiffness or pain in joints (check all that apply)
  - ☐ Finger ☐ Hands ☐ Wrist ☐ Elbows ☐ Shoulders ☐ Neck ☐ Back
  - ☐ Hip ☐ Knee ☐ Toes ☐ Foot ☐ Temporomandibular Joint
- Weakness of muscles or joints .... No Yes
- Any difficulty in walking .... No Yes
- Any pain in calves or buttocks on walking relieved by rest .... No Yes

Neuro-Psychiatric:
- ☐ Transient blindness ☐ Tremor ☐ Numbness in fingers ☐ Weakness
- Have you ever had counselling for your mental health? ... No Yes
- Have you ever been advised to see a psychiatrist? ...... No Yes
- Do you ever have, or have had, fainting spells? .... No Yes
- Convulsions .... No Yes
- Paralysis .... No Yes
- Problem with coordination .... No Yes
- Domestic violence .... No Yes
- Depression Symptoms (difficulty sleeping, loss of appetite loss of interest in activities, feelings of hopelessness) .... No Yes

Hematologic:
- Are you slow to heal after cuts? .... No Yes
- Anemia .... No Yes
- Phlebitis or Blood Clots in veins .... No Yes
- Have you had difficulty with bleeding excessively after tooth extraction or surgery? .... No Yes
- Have you had abnormal bruising or bleeding? .... No Yes
- Have you ever had a blood transfusion No Yes
  If yes please list dates

Source of information, if other than patient: ____________

Signature of person acquiring this information: ____________

____________ Provider ____________ Date ____________ Signature of Patient

HEALTH HABITS

CHECK (√) which substances you use or have use and describe how much you use or used.

	Caffeine	
	Tobacco	
	Drugs	
	Other	

CONDITIONS PLEASE CIRCLE symptoms you currently have or have had in the past AND approximate date of occurrence.

AIDS/HIV	______	Chemical Dependency	______	High Cholesterol	______	Psychiatric Care	______
Alcoholism	______	Chicken Pox	______	HIV Positive	______	Rheumatic Fever	______
Anemia	______	Diabetes	______	Kidney Disease	______	Scarlet Fever	______
Anorexia	______	Emphysema	______	Liver Disease	______	Stroke	______
Appendicitis	______	Epilepsy	______	Measles	______	Suicide Attempt	______
Arthritis	______	Glaucoma	______	Migraine Headaches	______	Thyroid Problems	______
Asthma	______	Goiter	______	Miscarriage	______	Tonsillitis	______
Bleeding disorders	______	Gonorrhea	______	Mononucleosis	______	Tuberculosis	______
Breast lumps	______	Gout	______	Mumps	______	Typhoid Fever	______
Bronchitis	______	Heart Disease	______	Pacemaker	______	Ulcers	______
Bulimia	______	Hepatitis	______	Pneumonia	______	Vaginal Infections	______
Cancer	______	Hernia	______	Polio	______	Venereal Disease	______
Cataracts	______	Herpes	______	Prostate Problem	______	Other illness not listed	______