

# ALL PATIENTS PLEASE COMPLETE THIS BEFORE YOU SEE DOCTOR

Name \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_ Date \_\_\_\_\_

## Review of Systems

You may be seeing us today for a minor complaint, but it is important that we are aware of any other symptoms that you have. It may not be feasible due to time constraints for us to address a long list of symptoms today, but we can make a follow-up appointment before you leave to further address the other symptoms you are experiencing. Please help us get this key information into your file. By answering the following questions you will allow us to insure you receive the best possible care from TienaHealth where we strive to:

**“Add Years to Your Life and Life to Your Years by Empowering You to Take Control of Your Health”**

**Do you currently have any of the problems listed below? Please circle all that apply.**

<p><b><u>Constitutional Symptoms</u></b></p> <ul style="list-style-type: none"> <li>• Anorexia (loss of appetite)</li> <li>• Fatigue</li> <li>• Fever</li> <li>• Chills</li> <li>• Night Sweats</li> <li>• Weight Gain of 10 lbs or more</li> <li>• Weight Loss of 10 lbs or more</li> <li>• Other _____</li> </ul>	<p><b><u>Skin</u></b></p> <ul style="list-style-type: none"> <li>• Dryness / Excessive Sweating</li> <li>• Change in Skin Spot or Mole</li> <li>• New Skin Lesions</li> <li>• Hair Loss</li> <li>• Nail Changes</li> <li>• Rash or Skin Color Changes</li> <li>• Easy Bruising</li> <li>• Other _____</li> </ul>	<p><b><u>Ear/Nose/Throat/Mouth</u></b></p> <ul style="list-style-type: none"> <li>• Deafness / Decreased Hearing</li> <li>• Earache / Ear Discharge</li> <li>• Tinnitus (Ringing in the Ears)</li> <li>• Nosebleeds</li> <li>• Frequent Runny Nose</li> <li>• Sinus Infections or Pain</li> <li>• Sore Throat</li> <li>• Other _____</li> </ul>
<p><b><u>HEENT</u></b></p> <ul style="list-style-type: none"> <li>• Color Blindness</li> <li>• Double Vision</li> <li>• Excessive Tearing</li> <li>• Eye Pain / Redness</li> <li>• Visual Disturbances</li> <li>• Visual Loss</li> <li>• Hoarseness / Voice Changes</li> <li>• Oral Ulcers</li> <li>• Wears Glasses / Contacts</li> <li>• Other _____</li> </ul>	<p><b><u>Respiratory and Heart</u></b></p> <ul style="list-style-type: none"> <li>• Chronic Cough</li> <li>• Decreased Exercise Tolerance</li> <li>• Shortness of Breath</li> <li>• Sputum Production / Color</li> <li>• Wheezing</li> <li>• Chest Pain</li> <li>• Rapid Heart Rate</li> <li>• Palpitations or Extra Heart Beats</li> <li>• High Blood Pressure</li> <li>• Other _____</li> </ul>	<p><b><u>Neurological</u></b></p> <ul style="list-style-type: none"> <li>• Dizziness</li> <li>• Headaches</li> <li>• Seizures</li> <li>• Decreased Memory</li> <li>• Weakness</li> <li>• Numbness</li> <li>• Difficulty Speaking Clearly</li> <li>• Other _____</li> </ul> <p><b>Date of Last Eye Exam</b> _____</p>
<p><b><u>Neck and Breasts</u></b></p> <ul style="list-style-type: none"> <li>• Neck Mass</li> <li>• Neck Pain</li> <li>• Neck Stiffness</li> <li>• Swollen Neck Glands</li> <li>• Breast Enlargement</li> <li>• Nipple Change</li> <li>• Nipple Discharge</li> <li>• Other _____</li> </ul>	<p><b><u>Gastrointestinal</u></b></p> <ul style="list-style-type: none"> <li>• Abdominal Pain</li> <li>• Change in Bowel Habits</li> <li>• Nausea / Vomiting</li> <li>• Diarrhea / Constipation</li> <li>• Esophageal Reflux or Burning</li> <li>• Excessive Gas / Bloating</li> <li>• Rectal Bleeding</li> <li>• Other _____</li> </ul>	<p><b><u>Musculoskeletal</u></b></p> <ul style="list-style-type: none"> <li>• Decreased Range of Motion of Joint</li> <li>• Joint Pain / Joint Swelling</li> <li>• Joint Redness</li> <li>• Muscle Atrophy</li> <li>• Muscle Cramps</li> <li>• Muscle Weakness</li> <li>• Muscle Pain</li> <li>• Other _____</li> </ul>
<p><b><u>Women Only</u></b></p> <ul style="list-style-type: none"> <li>• Pelvic Pain</li> <li>• Painful Intercourse</li> <li>• Vaginal Bleeding, Discharge or Odor</li> <li>• Vaginal Itching or Burning</li> <li>• Vaginal Dryness</li> </ul> <p><b><u>Menstrual Symptoms</u></b></p> <ul style="list-style-type: none"> <li>• Menstrual Irregularities</li> <li>• Painful Menses</li> <li>• Irritability / Mood Swings</li> <li>• Excessive Bleeding</li> <li>• Age at First Menses _____</li> <li>• Number of Pregnancies _____</li> </ul>	<p><b><u>Urinary System</u></b></p> <ul style="list-style-type: none"> <li>• Change in Urine Stream</li> <li>• Burning with Urination</li> <li>• Flank Pain (Back Pain Around Kidneys)</li> <li>• Urinary Frequency</li> <li>• Urinary Incontinence</li> </ul> <p><b><u>Additional Questions</u></b></p> <ul style="list-style-type: none"> <li>• Loss of Sex Drive</li> <li>• Erectile Dysfunction</li> <li>• Night time Urination: # of times per night _____</li> <li>• Other _____</li> </ul>	<p><b><u>Psychiatric</u></b></p> <ul style="list-style-type: none"> <li>• Change in Sleep Pattern</li> <li>• Excessive Daytime Sleepiness</li> <li>• Insomnia</li> <li>• Hypersomnia (sleeping too much)</li> <li>• Interrupted Sleep</li> <li>• Early Awakening</li> <li>• Anxiety / Panic Attacks</li> <li>• Depression</li> <li>• Frequent Crying</li> <li>• Inability to Concentrate</li> <li>• Family or Academic Conflicts</li> <li>• Suicidal Thoughts or Planning</li> <li>• Other _____</li> </ul>

\_\_\_\_\_ Check here if you have reviewed this sheet completely.