Kaner Medical Group Systems Review

D.O.B __________ Patient Name: ________________________________ Date: __________

Last First

Do you have now or have you recently had any problems related to the following systems? **Y**es or **N**o

Constitutional symptoms

	Y	N
Fever	☐	☐
Chills	☐	☐
Weight change over 10lbs.	☐	☐
Sleep disorder	☐	☐

Other ______________________

Integumentary

	Y	N
Skin rash	☐	☐
Boils / Sores	☐	☐
Persistent itch	☐	☐
Growth / moles / warts	☐	☐

Other ______________________

Eyes

	Y	N
Blurred vision	☐	☐
Double vision	☐	☐
Pain	☐	☐

Other ______________________

Ear/Nose/Throat/Mouth

	Y	N
Ear infection	☐	☐
Sore throat	☐	☐
Sinus problem	☐	☐
Hearing loss/difficulties	☐	☐

Other ______________________

Cardiovascular

	Y	N
Chest pain	☐	☐
Varicose veins / swelling	☐	☐
High blood pressure	☐	☐
Palpitations	☐	☐

Other ______________________

Respiratory

	Y	N
Wheezing	☐	☐
Frequent cough	☐	☐
Shortness of breath	☐	☐

Other ______________________

Gastrointestinal

	Y	N
Abdominal pain	☐	☐
Nausea / vomiting	☐	☐
Indigestion / heartburn	☐	☐
Constipation / diarrhea	☐	☐
Blood in stool	☐	☐

Other ______________________

Genitourinary

	Y	N
Urine Retention	☐	☐
Painful urination	☐	☐
Urinary Frequency	☐	☐
Wake at night to urinate X_______	☐	☐
Blood in urine	☐	☐
Irregular periods	☐	☐

Other ______________________________

Neurological

	Y	N
Headache	☐	☐
Tremors	☐	☐
Dizzy spells / fainting	☐	☐
Numbness / tingling / weakness	☐	☐
Seizures	☐	☐

Other ______________________________

Musculoskeletal

	Y	N
Joint pain	☐	☐
Neck pain	☐	☐
Back pain	☐	☐

Other ______________________________

Hematologic/Lymphatic

	Y	N
Swollen glands	☐	☐
Easy bruising or bleeding	☐	☐

Other ______________________________

Allergic / Immunologic

	Y	N
Hay fever	☐	☐
Asthma	☐	☐
Drug allergies	☐	☐

Other ______________________________

Endocrine

	Y	N
Excessive thirst	☐	☐
Too hot / cold	☐	☐
Tired / sluggish	☐	☐

Other ______________________________

Psychological

	Y	N
Are you generally satisfied with your life?	☐	☐
Do you feel severely depressed?	☐	☐
Do you feel suicidal?	☐	☐

Sexual History

	Y	N
Change in sex drive	☐	☐
Sexual performance satisfactory	☐	☐

Other ______________________________

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Physician / Provider Signature