NORTH SCOTTSDALE FAMILY MEDICINE

Patient Name: _____ Age _____

Patient DOB: ____ • ____ • ____ Today's Date: ____ • ____ • ____

Patient Review of Body Systems

Constitutional

			Comments
Weight Change	☐ Yes	☐ No	
Chills	☐ Yes	☐ No	
Night Sweats	☐ Yes	☐ No	
Other Symptoms?	☐ Yes	☐ No	

Eyes & Vision

			Comments
Double Vision	☐ Yes	☐ No	
Glaucoma	☐ Yes	☐ No	
Cataracts	☐ Yes	☐ No	
Other Symptoms?	☐ Yes	☐ No	

Ear, Nose & Throat

			Comments
Hearing Changes	☐ Yes	☐ No	
Sore Throat	☐ Yes	☐ No	
Sinus Problems	☐ Yes	☐ No	
Other Symptoms?	☐ Yes	☐ No	

Cardiovascular

			Comments
Chest Pain	☐ Yes	☐ No	
Irregular Heartbeat	☐ Yes	☐ No	
Swelling of Ankles	☐ Yes	☐ No	
Other Symptoms?	☐ Yes	☐ No	

Psychological

			Comments
Feeling anxious or nervous?	☐ Yes	☐ No	
Feeling depressed or sad?	☐ Yes	☐ No	
Are you often unhappy?	☐ Yes	☐ No	
Other Symptoms?	☐ Yes	☐ No	

Endocrine

			Comments
Excessive Thirst	☐ Yes	☐ No	
Feeling too Hot or Cold?	☐ Yes	☐ No	
Feeling Tired or Sluggish?	☐ Yes	☐ No	
Other Symptoms?	☐ Yes	☐ No	

Hematologic/Lymphatic

			Comments
Swollen Glands?	☐ Yes	☐ No	
Lumps or Bumps?	☐ Yes	☐ No	
Easy to Bruise?	☐ Yes	☐ No	
Other Symptoms?	☐ Yes	☐ No	

Allergic/Immunologic

			Comments
Hay Fever	☐ Yes	☐ No	
Drug Allergies	☐ Yes	☐ No	
Food Allergies	☐ Yes	☐ No	
Other Symptoms?	☐ Yes	☐ No	

Genitourinary

			Comments
Changes in Stream	☐ Yes	☐ No	
Bathroom at Night	☐ Yes	☐ No	
Blood in Urine	☐ Yes	☐ No	
Other Symptoms?	☐ Yes	☐ No	

Musculoskeletal

			Comments
Bone Pain	☐ Yes	☐ No	
Muscle Pain	☐ Yes	☐ No	
Joint Pain	☐ Yes	☐ No	
Other Symptoms?	☐ Yes	☐ No	

Integumentary *(Skin related)*

			Comments
Rash or Redness	☐ Yes	☐ No	
Lumps or Bumps	☐ Yes	☐ No	
Moles or Skin Tags	☐ Yes	☐ No	
Other Symptoms?	☐ Yes	☐ No	

Neurological

			Comments
Tremors	☐ Yes	☐ No	
Dizziness or Fainting Spells?	☐ Yes	☐ No	
Numbness or Tingling?	☐ Yes	☐ No	
Other Symptoms?	☐ Yes	☐ No	

Respiratory

			Comments
Wheezing	☐ Yes	☐ No	
Frequent Cough	☐ Yes	☐ No	
Shortness of Breath	☐ Yes	☐ No	
Other Symptoms?	☐ Yes	☐ No	

Gastrointestinal

			Comments
Abdominal Pain	☐ Yes	☐ No	
Nausea or Vomiting?	☐ Yes	☐ No	
Indigestion or Heartburn?	☐ Yes	☐ No	
Other Symptoms?	☐ Yes	☐ No	

Sexual History

			Comments
Question does not apply	☐		
Changes in Sex Drive?	☐ Yes	☐ No	
Changes in Performance?	☐ Yes	☐ No	
Other Changes?	☐ Yes	☐ No	

Periodic Information

Date–Last Tetanus Shot?	_____	☐ over 10 yrs
Date–Last Eye Exam?	_____	
Date–Last Colonoscopy?	_____	
Date–Last Prostate Screen?	_____	☐ N/A
Date–Last Stress Test?	_____	
Date–Last Bone Density Exam?	_____	☐ N/A
Date–Last Female Exam?	_____	☐ N/A
Date–Last Mammogram?	_____	☐ N/A

Physician Comments

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Physician Signature _____ *M.D.*