



# HILL PARK MEDICAL CENTER

## REVIEW OF SYSTEMS

Y= a problem you have now  
 N= never had this problems  
 P= had it in the past but not now

MEDICAL CENTER

Name: \_\_\_\_\_ Date: \_\_\_\_\_

<b>Blood Vessels (cont.)</b>	<b>Y</b>	<b>N</b>	<b>P</b>
Anemia			
Cold Hands/Feet			
Thrombophlebitis			
<b>Cardiovascular</b>	<b>Y</b>	<b>N</b>	<b>P</b>
Heart Disease			
High Blood Pressure			
Low Blood Pressure			
Blood Clots			
Phlebitis			
Rheumatic Fever			
Swelling in Ankles			
Angina			
Heart Murmurs			
Fainting			
Irregular Heartbeat			
Chest Pain			
<b>Gastrointestinal</b>	<b>Y</b>	<b>N</b>	<b>P</b>
Nausea			
Vomiting			
Vomiting Blood			
Trouble Swallowing			
Blood in Stool			
Pain/Cramps/Bloating			
Belching or Gas			
Gall Bladder Disease			
Liver Disease			
Heartburn			
Change in Appetite			
Constipation			
Diarrhea			
Black Stools			
Ulcers			

Hemorrhoids			
Bowel Movements—how often?			
<b>Urinary</b>	<b>Y</b>	<b>N</b>	<b>P</b>
Pain on Urination			
Frequency			
Frequent Infections			
Inability to Hold Urine			
Frequency at Night			
Kidney Stones			
<b>Male Reproductive</b>	<b>Y</b>	<b>N</b>	<b>P</b>
Testicular pain			
Sexually Active			
Premature Ejaculation			
Impotence			
Prostate Disease			
Hernias			
Testicular Masses			
Sexually Transmitted Disease			
What kinds?			
<b>Female Reproduction</b>	<b>Y</b>	<b>N</b>	<b>P</b>
Age of First Period			
Date of Last Period			
Age of last Period (if menopausal)			
Length of Cycles			
Are they Regular?			
Bleeding Between Cycles			
Clotting/Heavy Bleeding			
Discharge			
How many days each period?			
Menopause Symptoms			
Painful Periods			
Endometriosis			
Ovarian Cysts			

Sexually Active			
Sexual Difficulties			
Birth Control			
What type?			
Sexually Transmitted Disease			
What kinds?			
Abnormal Pap			
Breast Lumps			
Breast Pain			
Nipple Discharge			
PMS			
What symptoms?			
Number Pregnancies			
Number Live Births			
Number Miscarriages			
Number Abortions			
<b>General</b>			
How much do you weigh?			
Are you happy with your weight? Y/N			
<b>Childhood Illnesses (circle)</b>			
Mumps,			
Measles, Diptheria, Chicken Pox,			
German Measles, Rheumatic Fever			
<b>Immunizations (circle)</b>			
Polio,			
Tetanus, Measles/Mumps/Rubella,			
Pertussis, Diptheria, Meningitis, Other			
<b>X Rays and Special Studies</b>			
<i>List scans and X-rays you have had. Include</i>			
<i>CAT scans, MRI scans, X-rays, other special</i>			
<i>studies and Heart Studies like EKGs.</i>			