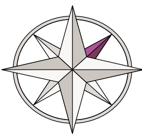

NORTHEAST ENDOCRINOLOGY ASSOCIATES P.A.

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Systems Review

Patient Name: ______________________________ Today's Date: ____ / ____ / ____

Current Primary Care Physician (First & Last Name): ______________________________

Reason for office visit: ______________________________

General

Do you feel well in general? ☐ Yes ☐ No
Is your weight stable? ☐ Yes ☐ No
Are you sleeping well? ☐ Yes ☐ No
Are you experiencing any:
Fatigue ☐ Yes ☐ No
Fever/Chills ☐ Yes ☐ No
Night Sweats ☐ Yes ☐ No
Easy bleeding/bruising ☐ Yes ☐ No
Food allergies/Seasonal allergies ☐ Yes ☐ No
Cold/heat intolerance ☐ Yes ☐ No

Ear/Eye

Ear pain ☐ Yes ☐ No
Hearing loss ☐ Yes ☐ No
Visual changes ☐ Yes ☐ No
Sinus problem ☐ Yes ☐ No

Heart/Lung

Describe any exercise: ______________________________
____

Shortness of breath with exercise ☐ Yes ☐ No
Coughing/Wheezing ☐ Yes ☐ No
Chest pain or discomfort with exercise? ☐ Yes ☐ No
Lower Extremity Swelling ☐ Yes ☐ No
Palpitations ☐ Yes ☐ No

Gastrointestinal

Abdominal pain ☐ Yes ☐ No
Constipation ☐ Yes ☐ No
Diarrhea ☐ Yes ☐ No
Loss of appetite ☐ Yes ☐ No
Nausea/vomiting ☐ Yes ☐ No
Colonoscopy (Date): ____ / ____ / ____

Urinary Symptoms

Dysuria (painful urination) ☐ Yes ☐ No
Hematuria (blood in urine) ☐ Yes ☐ No
Yeast infection ☐ Yes ☐ No

Nervous System

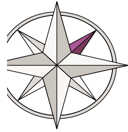
Dizziness ☐ Yes ☐ No
Extremity numbness/weakness ☐ Yes ☐ No
Headaches ☐ Yes ☐ No
Memory loss ☐ Yes ☐ No
Seizures/Tremors ☐ Yes ☐ No
Anxiety ☐ Yes ☐ No
Depression ☐ Yes ☐ No

Skin

Hair changes /hair loss ☐ Yes ☐ No
Hives ☐ Yes ☐ No
Rash ☐ Yes ☐ No

Musculoskeletal

Back/Neck pain ☐ Yes ☐ No
Joint pain ☐ Yes ☐ No
Muscle weakness ☐ Yes ☐ No



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If you are a Man:

Date of your last prostate exam: ____ / ____ / ____

Erectile dysfunction ☐ Yes ☐ No

Name of Urologist: ____________________

If you are a Woman:

Last menstrual period: ____ / ____ / ____

Last GYN exam: ____ / ____ / ____

Last mammogram: ____ / ____ / ____

Last bone density test: ____ / ____ / ____

Result: ____________________

Name of Gynecologist: ____________________

Have you ever used Tobacco:

☐ Current ☐ Former ☐ Never

Ever tried to quit ☐ Yes ☐ No **Age** quit: ______

IF YOU ARE DIABETIC:

Are you experiencing low blood sugars? ☐ Yes ☐ No

If yes, how many times per week? ________

How often do you check your blood sugar? ________

Type of Meter____________________

Have you had a recent eye exam? ☐ Yes ☐ No

Date of eye exam: ____ / ____ / ____

Eyes dilated ☐ Yes ☐ No

Name of eye doctor: ____________________

Eye Diagnosis: ____________________

____

Are there any updates in your family history (close relatives)?

____

____

If this is a follow up visit, have you had any hospitalization, accident or illness since your last visit? ☐ Yes ☐ No

If yes____________________

Prescription refills needed (list):

____

____

Preferred Pharmacy and phone number:

____

____

Are there any problems you would like to discuss?

____

____

____