NORTHEAST
ENDOCRINOLOGY
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# Systems Review

Patient Name: _____ Toda3y'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 |
| Cold/heat intolerance | ☐ Yes | ☐ No |

## Ear/Eye

| | | |
|---|---|---|
| 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 |

## 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 |
| Rash | ☐ Yes | ☐ No |

## Musculoskeletal

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

## 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? _____

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

Date of eye exam: ____ / ____ / ____

Eyes dilated ☐ Yes ☐ No

Name of eye doctor: _____

Have you been told you have diabetic eye changes?

☐ Yes ☐ No

**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?**

_____

_____

_____

_____