NORTHEAST
ENDOCRINOLOGY
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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
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?

_____

_____

_____

_____