HOLLAND COMMUNITY Health CENTER

Systems Review

As you review the following, please check any of those problems which apply to you:

Name:____Date of birth:____________________

GENERAL	NOSE	KIDNEY/URINE/BLADDER
☐ Recent weight gain – amount:__________	☐ Nosebleeds	☐ Pain or burning on urination
☐ Recent weight loss – amount:__________	☐ Nasal congestion	☐ Blood in urine
☐ Fatigue	☐ Dryness	BLOOD
☐ Fever	☐ Nasal ulcers	☐ Anemia
☐ Night sweats	PSYCHIATRIC	☐ Bleeding tendency
☐ Sleep disturbances	☐ Depression	☐ Blood clots/ phlebitis
NERVOUS SYSTEM	☐ Anxiety	☐ Low platelet count
☐ Headache	☐ Memory loss	SKIN
☐ Dizziness	HEART & LUNGS	☐ Easy bruising
☐ Fainting	☐ Pain in chest	☐ Redness
☐ Muscle spasm or weakness	☐ Irregular heartbeat	☐ Rash
☐ Numbness or tingling sensation	☐ Sudden change in heartbeat	☐ Hives
☐ Memory loss	☐ Shortness of breath	☐ Sun sensitive (sun allergy)
☐ Seizure	☐ Difficulty in breathing at night	☐ Tightness
☐ Tremors	☐ Swollen legs or feet	☐ Nodules/bumps
EARS	☐ High blood pressure	☐ Hair loss
☐ Hearing loss	☐ Heart murmurs	☐ Color changes of hands/ feet in the cold
☐ Ear drainage	☐ Cough	☐ Tick bite in the last 5 years
☐ Ringing of ears/tinnitis	☐ Coughing of blood	MUSCLES/JOINTS/BONES
EYES	☐ Wheezing	☐ Morning stiffness lasting how long?
☐ Pain	☐ Pleurisy	☐ Joint pain
☐ Redness	STOMACH AND INTESTINES	☐ Muscle weakness
☐ Dryness	☐ Nausea	☐ Muscle tenderness
☐ Vision loss	☐ Increasing constipation	☐ Joint swelling –
☐ Double vision	☐ Persistent diarrhea	List joint affected in the last 6 mo.:
☐ Light sensitivity	☐ Blood in stools	1.
MOUTH	☐ Heartburn	2.
☐ Mouth sores	☐ Ulcers	3.
☐ Dry mouth	☐ Acid reflux	4.
☐ Hoarseness	☐ Vomiting	5.
☐ Swollen glands		
☐ Other:		

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Systems Review

PREVIOUS OPERATIONS			
Type	**Year**	**Type**	**Year**
1.		4.	
2.		5.	
3.		6.	

Any previous fractures: ☐ Yes ☐ No Describe:______________________________

Any other serious injuries: ☐ Yes ☐ No Describe:______________________________

PAST MEDICATIONS

Please review this list of “arthritis” medications. As accurately as possible, try to remember which medications you have taken, how long you were taking the medication, the effectiveness of the medication, and any reactions you have had.

Drug name	Dosage	Length of time	Please rate how effective			Reactions
			Not at all	Some	Very	
Cortisone/Prednisone						
Plaquenil/hydroxychloroquine						
CellCept						
Methotrexate						
Imuran/Azathioprine						
Cytoxan/Cyclophosphamide						
Azulfidine/Sulfasalazine						
Gold (shots or pills)						
Arava						
Enbrel						
Remicade						
Humira						

Drug allergies

☐ Yes ☐ No Describe: ______________________________