Dr. Joan Sy Medical Corp.

SYSTEM REVIEW

GENERAL		
Do you eat a well balanced diet?	No	Yes
Approx. weight now _____ 1 yr ago _____		
Maximum weight _____		
Exercise? Frequency / Wk _____		
Activities _____		
Any Sexual Concerns?	No	Yes
Year of Last Complete Physical		
Headaches	No	Yes
Glasses/contacts	No	Yes
Double vision	No	Yes
Eye disease or injury	No	Yes
Year last checked for glaucoma		
Itching eyes or nose/hay fever	No	Yes
Septal deviation / polyps (circle)	No	Yes
Nosebleeds	No	Yes
Sinus trouble	No	Yes
Ear disease	No	Yes
Impaired hearing	No	Yes
Ringing in the ears	No	Yes
Hoarseness	No	Yes
NECK		
Stiffness	No	Yes
Enlarged glands	No	Yes
Injury	No	Yes
RESPIRATORY		
Coughing up blood	No	Yes
Chronic cough (including Smoker's Cough)	No	Yes
Wheezing	No	Yes
Shortness of breath	No	Yes
How many blocks can you walk without having to stop to catch your breath? _____		
Night sweats	No	Yes
Skin test for tuberculosis	No	Yes
If yes, year tested and results _____		
Year of last chest x-ray _____		
CARDIOVASCULAR		
Chest pain or angina pectoris	No	Yes
Shortness of breath when lying fiat	No	Yes
Pain in legs on walking, relieved by rest	No	Yes
Varicose veins	No	Yes
Ankles often badly swollen	No	Yes
Heart murmur	No	Yes
Rapid, hard or skipped heart beats	No	Yes
Year of last EKG? _____		
Have you had a stress treadmill?	No	Yes
GASTROINTESTINAL		
Change in appetite	No	Yes
Heartburn or indigestion	No	Yes
Sour taste in throat or mouth	No	Yes
Intolerance to spicy foods, coffee or alcohol	No	Yes
Ever vomited blood?	No	Yes
Do foods stick in throat?	No	Yes
Gallbladder trouble/ intol. to greasy foods	No	Yes
Intolerance to milk products	No	Yes
Hiatal Hernia	No	Yes
Pancreatitis	No	Yes
Do you often vomit?	No	Yes
Crampy abdominal pain	No	Yes
Chronic constipation	No	Yes
Frequent diarrhea	No	Yes
Change in bowel habits	No	Yes
Bloody or black bowel movements	No	Yes
Hemorrhoids or piles	No	Yes

GENITORURINARY		
Loss of urine when cough or sneeze	No	Yes
Kidney or bladder infection (circle)	No	Yes
Burning or frequent urination (circle)	No	Yes
Feeling must go immediately?	No	Yes
Do you have to get up at night to urinate? #	No	Yes
Blood in urine	No	Yes
Kidney stones	No	Yes
Swelling of hands and feet	No	Yes
Difficulty starting urination?	No	Yes
Decrease in strength of stream	No	Yes
Penile Discharge	No	Yes
Date of last prostate exam _____		
MUSCULOSKELETAL		
Significant Arthritis / Joint pain	No	Yes
Low back pain	No	Yes
Muscle weakness or tenderness	No	Yes
Difficulty walking	No	Yes
Fractures (list)	No	Yes
SKIN		
Skin disorders (list)	No	Yes
NEUROLGIC /PSYCHIATRIC		
Numbness / paralysis (circle)	No	Yes
Fainting spells	No	Yes
Memory loss	No	Yes
Dizziness	No	Yes
Do you have trouble sleeping?	No	Yes
Are you often depressed?	No	Yes
Are you often anxious or nervous?	No	Yes
Do you ever wish you were dead and away from it all?	No	Yes
Do you often worry?	No	Yes
Have you ever been under psychiatric care?	No	Yes
HEMATOLOGIC		
Excessive bleeding or abnormal bruising	No	Yes
ENDOCRINE		
Crave large amounts of fluids	No	Yes
Intolerance to slightly warm rooms	No	Yes
Intolerance to slightly cool rooms	No	Yes
Change in textures of hair or skin	No	Yes
Change in voice (as an adult)	No	Yes
Hair loss	No	Yes
Diminished sex drive	No	Yes
Darkening of skin	No	Yes
GYNECOLOGICAL (This section for women only)		
Age when periods started _____ Years old		
Frequency: every _____ Days; Last Period _____		
Are they abnormal or irregular?	No	Yes
Menopausal Age _____	No	Yes
Number of pregnancies _____ C/sections _____		
Term deliveries _____ Premature _____		
Miscarriages _____ Abortions _____		
Pelvic inflammatory disease	No	Yes
Pain with intercourse	No	Yes
Date of last cancer smear _____ Normal?	No	Yes
Breast masses, lumps, cyst (circle)	No	Yes
Nipple discharge	No	Yes
Skin discoloration / dimpling	No	Yes
Family history of breast cancer	No	Yes
Date of last mammogram	No	Yes
Did someone other than the patient help fill this out?	No	Yes

Patient Signature: _____

Reviewing Physician: _____

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