

Pulmonary medicine-review of systems (female)

Patient name _____ Date _____

Please check any symptom below that you have. Ask your provider if you do not understand the question or want to give more specific details.

Constitutional

- | | | |
|---------------------------------|---|---|
| <input type="checkbox"/> Fever | <input type="checkbox"/> Feeling poorly | <input type="checkbox"/> Recent weight gain _____ lbs |
| <input type="checkbox"/> Chills | <input type="checkbox"/> Feeling tired | <input type="checkbox"/> Recent weight loss _____ lbs |

Eyes

- | | | |
|-----------------------------------|--|------------------------------------|
| <input type="checkbox"/> Eye pain | <input type="checkbox"/> Eyesight problems | <input type="checkbox"/> Dry eyes |
| <input type="checkbox"/> Red eyes | <input type="checkbox"/> Discharge from eyes | <input type="checkbox"/> Eyes itch |

Ear, Nose, Throat

- | | | |
|--|--|--------------------------------------|
| <input type="checkbox"/> Earache | <input type="checkbox"/> Nose bleeds | <input type="checkbox"/> Sore throat |
| <input type="checkbox"/> Loss of hearing | <input type="checkbox"/> Nasal discharge | <input type="checkbox"/> Hoarseness |

Cardiovascular

- | | | |
|---------------------------------------|--|---|
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Fast heart rate | <input type="checkbox"/> Leg cramps with exercise |
| <input type="checkbox"/> Palpitations | <input type="checkbox"/> Slow heart rate | <input type="checkbox"/> Swelling of lower leg(s) |

Respiratory

- | | | |
|--|---|---|
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Cough | <input type="checkbox"/> Short of breath when laying flat |
| <input type="checkbox"/> Wheezing | <input type="checkbox"/> Short of breath at night | <input type="checkbox"/> Short of breath with activity |

Gastrointestinal

- | | | |
|---|---------------------------------------|---|
| <input type="checkbox"/> Abdominal pain | <input type="checkbox"/> Constipation | <input type="checkbox"/> Heartburn |
| <input type="checkbox"/> Vomiting | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Black/bloody bowel movements |

Genitourinary

- | | | |
|--|--|--|
| <input type="checkbox"/> Pain with urination | <input type="checkbox"/> Pelvic pain | <input type="checkbox"/> Vaginal discharge |
| <input type="checkbox"/> Urine leaking | <input type="checkbox"/> Painful periods | <input type="checkbox"/> Abnormal vaginal bleeding |

Musculoskeletal

- | | | |
|---|---|---|
| <input type="checkbox"/> Achy joints | <input type="checkbox"/> Swelling in joints | <input type="checkbox"/> Pain in arms or legs |
| <input type="checkbox"/> Pain in joints | <input type="checkbox"/> Stiff joints | <input type="checkbox"/> Swelling of lower leg(s) |

Integumentary

- | | | |
|---|---|--------------------------------------|
| <input type="checkbox"/> Abnormal patch of skin | <input type="checkbox"/> Itching | <input type="checkbox"/> Breast pain |
| <input type="checkbox"/> Skin wound | <input type="checkbox"/> Change in a mole | <input type="checkbox"/> Breast lump |

Neurological

- | | | |
|---|------------------------------------|---|
| <input type="checkbox"/> Confusion | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Weak or numb limb |
| <input type="checkbox"/> Seizures or convulsion | <input type="checkbox"/> Fainting | <input type="checkbox"/> Difficulty walking |

Psychiatric

- Suicidal thoughts
- Disturbed sleep
- Anxiety
- Depression
- Change in personality
- Emotional problems

Endocrine

- Bulging eye(s)
- Hot flashes
- Feeling of weakness
- Deepening of the voice
- General muscle weakness

Heme/Lymph

- Easy bleeding
- Easy bruising
- Swollen glands
- Swollen neck glands

Other problems (please explain):

Sleep history

- Daytime sleepiness
- Snoring
- Helps to move legs
- Insomnia
- Sleep apnea
- Change in sleep pattern
- Waking frequently at night
- Urge to move legs at rest or in bed

When is your bedtime? _____

How long does it take you to fall asleep? _____

How many times do you awaken at night? _____

What time do you wake up in the morning? _____

How many hours of sleep do you get at night? _____

Tuberculosis

Do you know if you've had exposure to someone with TB? No Yes

Have you had previous TB tests? No Yes If yes, result: _____

Have you had any treatment for positive TB test? No Yes

Have you had any diagnosis of active TB? No Yes, treatment used _____

Treatment lasted _____ months

Patient signature: _____ Date: _____



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