Holland Hospital
PHYSICIAN OFFICES

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	☐ Other	SKIN
☐ Dizziness	HEART & LUNGS	☐ Easy bruising
☐ Fainting	☐ Pain in chest	☐ Redness
☐ Muscle spasm	☐ 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: _____

Holland Hospital

My Medication Profile

Patient Name: _____ Date of birth: _____ Date completed: _____

Medication Name	Dosage	Frequency	Diagnosis	Prescribing physician
Include all prescription and non-prescription drugs, vitamins, and supplements	Include mg, mcg, units, puffs, drops	How many times per day? After meals? At bedtime?	For what reason is this medication being prescribed to you?	Who is prescribing this medication for you?

To assist us in meeting your needs today, please answer the following questions.

Name: _____ DOB: _____ Date: _____

Since my last visit, I'm doing: ☐ Very Well ☐ Well ☐ Fair ☐ Poor ☐ Very Poor

Compared to my last visit here, I'm doing: ☐Same ☐ Better ☐Worse

What bothers you most today? _____

_____

On a scale of 0-10, with 0 being no pain and 10 being extreme pain, how much pain are you in?

0☐ 1☐ 2☐ 3☐ 4☐ 5☐ 6☐ 7☐ 8☐ 9☐ 10☐

How long is your morning stiffness? (check the box)

☐None ☐<10min ☐15min ☐30min ☐45min ☐1hr ☐2hr ☐4hr ☐All day

Describe your night-time sleep: (check the box)

☐Great ☐Normal ☐Fair ☐Poor ☐Very Poor ☐Can't Fall Asleep

☐Can't Stay Asleep ☐Wake Early ☐Snoring ☐Restless Legs ☐Night Pain

Since last visit, I've had:

☐No Problems

☐Falls / Injuries _____

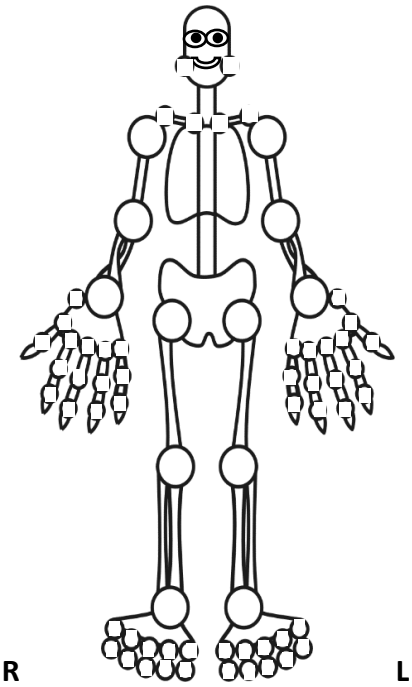
☐New Diagnosis _____

☐Infection _____

☐Surgery _____

☐Hospitalization _____

Please check the areas below that are bothering you most today.



R **L**

If you are tying Hydroxychloroquine (Plaquenil), when was your last Hydroxychloroquine specific Eye Exam? _____ Where was it completed? _____