ANNUAL EXAM SYSTEM REVIEW	**Name:**	**DOB:**	**Date:**

NOTE TO THE PATIENT: Please review each question/item below and check any items that apply to you. Please circle yes (**Y**) *identifying which items are **NEW** or **DIFFERENT.*** If you have any **special or specific concerns**, please list them **here**:

System and Problem	Circle if YES	How Long?	System and Problem	Circle if YES	How Long?
1-General:			***8-Female genital:***		
Fevers or chills	Y		Last menstrual period:_____	Y	
Night sweats	Y		Recent irregular or change in periods	Y	
Weight loss [Unexpected]	Y		Vaginal irritation, burning or discharge	Y	
Weight gain [Unexpected]	Y		Unexpected menstrual bleeding	Y	
Excessive **fatigue**	Y		Painful periods	Y	
Excessive daytime **sleepiness**	Y		***9-Musculoskeletal:***		
Loss of or poor appetite	Y		**Joint aches or pains**	Y	
Poor Sleep (falling or staying)	Y		Joint swelling or stiffness	Y	
2-ENT			Decreased joint range of motion	Y	
Dramatic **changes in vision**	Y		Bone pain	Y	
Tinnitus/ringing in ears	Y		***10-Skin and Breasts:***		
Hearing loss	Y		Nipple discharge	Y	
Nose bleeds	Y		Non-healing sores	Y	
Sinus pressure/pain or Ear pain	Y		**Concerning moles, lumps, or growths**	Y	
Sore throat	Y		**Breast Lump[s]**	Y	
Hoarseness more than 2 weeks	Y		Concerning rash	Y	
3-Cardiovascular:			**Breast pain** or tenderness	Y	
Chest pain or pressure w/ exertion	Y		***11-Lymphatic/Hematologic***		
Unusual **shortness of breath**	Y		**Swollen glands @** neck, armpit, groin	Y	
Palpitations	Y		Bruising concerns	Y	
Swelling of extremities[**edema]**	Y		***12-Neurologic:***		
Calf pain when walking	Y		New or more severe **Headaches**	Y	
4-Respiratory:			Fainting or lightheadedness	Y	
Persistent coughing or wheezing	Y		**Memory problems**	Y	
Blood tinged sputum	Y		Numbness or tingling (in hands or feet, etc)	Y	
Pain with deep breathing	Y		New balance problems	Y	
5-Gastrointestinal:			Muscle weakness	Y	
Frequent **heartburn**	Y			Y	
Pain or difficulty swallowing [dysphagia]	Y		***13-Psychiatric:***		
Change in bowel habits	Y		**Feeling sad, blue, irritable, angry**	Y	
Nausea or vomiting	Y		Loss of sex drive	Y	
Increased constipation	Y		**Suicidal** thoughts	Y	
Frequent diarrhea or mucous	Y		Feeling **anxious**	Y	
Blood in stool or on toilet paper	Y		Preoccupations or compulsions	Y	
Black, tarry stools	Y		Loss of ambition or motivation	Y	
Indigestion or bloating problems	Y		Decrease or loss of interest in hobbies	Y	
Abdominal **pain**	Y		***14-Allergy and Immunologic:***		
6-Urinary Tract:			Hay fever	Y	
Burning or urgency of urination	Y		Itchy, watery eyes or nose	Y	
Increased urinary frequency	Y		Itchy or sensitive skin	Y	
Difficulty controlling urination	Y		Persistent clear nasal/**postnasal drainage**	Y	
Blood in urine (or change in color)	Y		Excessive or frequent infections	Y	
7-Male genital:			***15-Endocrine:***		
Testicle or scrotal lumps/discomfort	Y		Markedly increased thirst	Y	
Erectile dysfunction	Y		Markedly increased urination	Y	
Changes in urinary	Y		Intolerance of Heat or cold	Y	

Patient signature:_____ **Date:**_____

Physician Reviewed by: _____ **Date:**_____

ARKTOS
DIRECT CARE