Michiana Spine, Sports & Occupational Rehab, P.C.
3740 Edison Lakes Parkway, Mishawaka, IN 46545 Toll Free (888) 734-2246 Fax (574) 252-4161

SYSTEM REVIEW

Patient Name _____ Date of Birth _____ Todays Date _____

Have you had any of the following in the last year?
Please circle appropriate answer

Good general health lately	Yes	No
Recent weight change	Yes	No
Fatigue	Yes	No
Fevers	Yes	No

EYES

Eye disease or injury	Yes	No
Wear glasses/contact lens	Yes	No
Blurred or double vision	Yes	No
Glaucoma	Yes	No

EARS/NOSE/MOUTH/THROAT

Hearing loss or ringing	Yes	No
Earaches or drainage	Yes	No
Chronic sinus problem or rhinitis	Yes	No
Nose bleeds	Yes	No
Dry mouth	**Yes**	No
Bleeding gums	Yes	No
Sore Throat or voice change	Yes	No
Runny nose	**Yes**	No

CARDIOVASCULAR

Heart trouble	Yes	No
Chest pain or angina pectoris	Yes	No
Palpitation	Yes	No
Shortness of Breath walking or lying flat	Yes	No
Swelling of feet ankles or hands	**Yes**	No

RESPIRATORY

Chronic or frequent coughs	Yes	No
Spitting up blood	Yes	No
Shortness of breath	Yes	No
Asthma or wheezing	Yes	No
Loss of appetite	Yes	No

GASTROINTESTINAL

Constipation	**Yes**	No
Nausea or vomiting	**Yes**	No
Frequent diarrhea	**Yes**	No
Stomach or duodenal ulcer	Yes	No
Pain or change in bowel movements	Yes	No
Rectal bleeding or blood in stool	Yes	No
Abdominal pain or heartburn	**Yes**	No
Abdominal cramping	**Yes**	No

Genitourinary

Frequent urination	Yes	No
Burning or painful urination	Yes	No
Blood in urine	Yes	No
Change in force or strain when urinating	Yes	No
Incontinence or dribbling	Yes	No

PSYCHIATRIC

Memory loss or confusion	**Yes**	No
Nervousness or anxiety	**Yes**	No
Depression	Yes	No
Insomnia	Yes	No

Patient Signature: _____

M.D. Review: _____

MUSCULOSKELETAL

Joint Pain	Yes	No
Weakness of muscles or joints	Yes	No
Muscle pain or cramps	Yes	No
Back pain	Yes	No
Cold extremities	Yes	No
Difficulty in walking	Yes	No
Foot Pain	Yes	No

INTEGUMENTARY (skin)

Rash or itching	**Yes**	No
Change in skin color	Yes	No
Change in hair or nails	Yes	No
Varicose veins	Yes	No
Ulcers	Yes	No
Corn or callus	Yes	No

NEUROLOGICAL

Frequent or recurring headaches	**Yes**	No
Light headed or dizzy	Yes	No
Convulsions or seizures	Yes	No
Numbness or tingling sensations	Yes	No
Tremors	Yes	No
Paralysis	Yes	No
Stroke	Yes	No
Head injury	Yes	No

ENDOCRINE

Glandular or hormone problems	Yes	No
Thyroid disease	Yes	No
Diabetes	Yes	No
Excessive thirst or urination	Yes	No
Heat or cold intolerance	Yes	No
Skin becoming dryer	Yes	No
Slow to heal after cuts	Yes	No
Bleeding or bruising tendency	**Yes**	No
Anemia	Yes	No
Phlebitis	Yes	No

Comments: _____

_____

4-A's _____

Date _____