ENVIRONMENTAL HISTORY SYSTEMS REVIEW FORM

NAME____________________________________________DATE________________

Please complete the following. Number the items with a 1 for MILD, 2 for MODERATE, and 3 for SEVERE. Leave the line blank if it does not apply to you.

SKIN

_____Abnormal pigmentation, brown spots
_____Acne
_____Change in a mole
_____Dry/scaly skin
_____Easy bruising
_____Frequent itching
_____Flushing/hot flashes
_____Hair loss
_____Frequent infections/boils
_____Hives, rash, eczema
_____Oily skin
_____Skin cancer
_____Skin disease

EYES

_____Bags/dark circles
_____Blurred vision
_____Cataract/glaucoma
_____Swollen, red, sticky eyelids
_____Watery, itchy eyes
_____Other eye diseases/injury

EARS

_____Drainage from ear
_____Earaches, infections
_____Itchy ears
_____Hearing loss
_____Ringing in the ears
NOSE

______Frequent stuffy/runny nose
______Frequent colds
______Hay fever
______Nose bleeds
______Sneezing attacks
______Sinus Problems

CIRCULATORY

______Pulsations in abdomen
______Abnormal exam/test
______Chest pain/tightness
______Cold hands/feet
______Color changes in toes/feet
______Difficulty walking 1-2 blocks
______Discoloration/sores of feet
______Heart murmur
______Mitral valve prolapse
______Heart attack/Heart disease
______High cholesterol/Triglycerides
______High/Low Blood Pressure
______Leg cramps at rest or night
______Palpitations
______Rapid/Skipped Heartbeats
______Stroke
______Swelling of hands/feet/ankle
______Varicose veins/Phlebitis

MOUTH/THROAT

______Bleeding gums
______Canker sores
______Chronic coughing
______Dry mouth
______Gagging, clearing the throat
______Lump in the throat
______Sore throat
______Hoarseness/loss of voice
______Sore tongue
______Swollen/discolored tongue/lips
RESPIRATORY

_____Asthma/Chronic Bronchitis/Emphysema
_____Chest congestion/Frequent Cough
_____Coughing up blood
_____Frequent exposure to chemicals/dust/etc.
_____Pleurisy/Pneumonia/Tuberculosis
_____Shortness of breath/Difficulty breathing
_____Smoking
_____Sputum
_____Wheezing
_____Any other lung trouble

DIGESTIVE

_____Appetite (poor, medium, good)
_____Hemorrhoids
_____Belching/passing gas
_____Hepatitis/Liver trouble
_____Bleeding/Black stools
_____Jaundice
_____Bloated feeling
_____Mucous in stool
_____Colitis/Diverticulitis/Polyps
_____Nausea/Vomiting
_____Constipation/Painful bowel movements
_____Diarrhea
_____Peptic ulcer
_____Gallbladder disease
_____Heartburn/Indigestion
KIDNEY/BLADDER

_____Blood/Sugar/Pus in urine
_____Burning/Painful urination
_____Frequent urinating
_____Night time urination
_____Gravel/stone in urine
_____Kidney/Bladder infection
_____Kidney/Bladder disease
_____Water retention
_____Weak bladder

JOINTS/MUSCLES

_____Swelling/pains/aches in joints
_____Gout
_____Arthritis
_____Pain/aches in muscles
_____Back/Neck pains
_____Spasms/cramps in muscles
_____Bursitis
_____Rheumatism
_____Difficulty in walking
_____Sciatica
_____Gout
_____Tremors of hands/feet
_____Pain/aches/cramps/spasms in muscles
_____Rheumatism
NEUROLOGICAL

- Back pains
- Convulsions
- Epilepsy
- Fainting spells
- Frequent headaches
- Head injury/Concussion
- Loss of coordination
- Memory Problems
- Migraine headaches
- Multiple Sclerosis
- Muscle twitchings
- Nervous Disease
- Neuritis
- Paralysis
- Radiating pain down the legs
- Tingling/Numbness of arms, legs, face
- Weakness of arms, legs, or face

ENDOCRINE

- Heat/Cold intolerance
- Diabetes
- Steroid prescriptions in past
- Excessive thirst
- Excessive appetite

HEMATOLOGICAL

- Abnormal bleeding
- Anemia (past, present)
- Blood disease
- Cuts/bruises slow to heal
- Phlebitis/thrombosis

Nervous Disease
- Phlebitis/Thrombosis
- Neuritis
- Paralysis
- Radiating pain down the legs
- Tingling/Numbness of arms, legs, face
- Weakness of arms, legs, or face
<table>
<thead>
<tr>
<th>GENERAL</th>
<th>MIND</th>
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<tbody>
<tr>
<td>_____ Excessive fatigue</td>
<td>_____ Confusion</td>
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<tr>
<td>_____ Frequent anger/irritability</td>
<td>_____ Difficulty making decisions</td>
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<td>_____ Frequent nightmares</td>
<td>_____ Irritability</td>
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<td>_____ Frequent crying spells</td>
<td>_____ Learning disabilities</td>
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<td>_____ Frequent depressed spells</td>
<td>_____ Poor concentration</td>
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<tr>
<td>_____ Frequent illness</td>
<td>_____ Poor memory</td>
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<td>_____ Frequent loneliness</td>
<td>_____ Slurred speech</td>
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<td>_____ Frequent suicidal thoughts</td>
<td>_____ Stuttering/stammering</td>
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<td>_____ General weakness/tires easily</td>
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<td>_____ Insomnia/sleep related issues</td>
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<td>_____ Loss of ambition</td>
<td>_____ Binge eating/drinking</td>
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<td>_____ Mood swings</td>
<td>_____ Compulsive eating</td>
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<td>_____ Nervous breakdown</td>
<td>_____ Craving certain foods</td>
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<td>_____ Poor general health</td>
<td>_____ Water retention</td>
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<td>_____ Stressful job/Life</td>
<td>_____ Over/Underweight</td>
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<tr>
<td>_____ Unusual fears</td>
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<tr>
<td>_____ Unusual Stress/Anxiety</td>
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<td>_____ Reduced sex drive</td>
<td>_____ Lethargy/Apathy</td>
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<td>_____ Other sexual problems</td>
<td>_____ Hyperactivity</td>
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MALES

_____Discharge from penis
_____Painful/swollen testicles
_____Prostate trouble
_____Trouble with ejaculation
_____Trouble with erection
_____Sexually transmitted disease
_____Date of last prostate exam

FEMALES

_____Irregular/painful menses
_____Bleeding between periods
_____Cysts/Tumors of Ovary/Uterus
_____Sex drive reduced/lacking
_____Pain during intercourse
_____Vaginal dryness
_____Vaginal infections/itching/discharge
_____Hair growth on face or body
_____Hot flashes/mood swings/depression
_____Date of last menstrual period
_____Date of last mammogram
_____Date of last PAP smear