Tufts Medical Center

HEALTH PROBLEMS CHECKLIST

Your doctor will likely cover this checklist, also known as the Review of Systems.
It is provided as a tool to help you recall any health problems you may have experienced in the past 3 months.

Symptom	Yes	No	
Often feeling tired (fatigued)	Yes ___	No ___	
Unexplained weight loss	Yes ___	No ___	
Unexplained weight gain	Yes ___	No ___	
Unexplained fevers or night sweats	Yes ___	No ___	
Rashes	Yes ___	No ___	
Changes with skin mole(s)	Yes ___	No ___	Location: ___________________
New lump(s)	Yes ___	No ___	Location: ___________________
Easy bruising or bleeding	Yes ___	No ___	
Frequent headaches	Yes ___	No ___	
Trouble with vision that is not corrected by glasses or contacts	Yes ___	No ___	Last eye exam: ______________
Trouble with hearing	Yes ___	No ___	Last hearing test: ____________
Frequent sinus congestion or "hay fever"	Yes ___	No ___	
Dental problems	Yes ___	No ___	Last dental exam: ___________
Difficulty swallowing	Yes ___	No ___	
Rapid or irregular heart beat	Yes ___	No ___	
Chest pain	Yes ___	No ___	
Swelling or puffiness of feet or hands	Yes ___	No ___	
Shortness of breath	Yes ___	No ___	
Frequent cough	Yes ___	No ___	
Wheezing	Yes ___	No ___	
Loss of appetite	Yes ___	No ___	
Frequent nausea or vomiting	Yes ___	No ___	
Frequent heartburn	Yes ___	No ___	
Frequent abdominal pain	Yes ___	No ___	
Frequent diarrhea	Yes ___	No ___	
Frequent constipation	Yes ___	No ___	
Blood in stools	Yes ___	No ___	
Pain or burning with urination	Yes ___	No ___	
Need to urinate frequently	Yes ___	No ___	
Blood in urine	Yes ___	No ___	
Sexual problems	Yes ___	No ___	
Hot flashes	Yes ___	No ___	
Joint or bone pain	Yes ___	No ___	Location: ___________________
Frequent muscle aches	Yes ___	No ___	Location: ___________________
Other frequent pain	Yes ___	No ___	Location: ___________________
Tremors of hands	Yes ___	No ___	
Problems with coordination	Yes ___	No ___	
Seizures (convulsions)	Yes ___	No ___	
Dizziness	Yes ___	No ___	
Memory problems	Yes ___	No ___	
Often feeling sad or down	Yes ___	No ___	
Often feeling anxious or worried	Yes ___	No ___	
Frequent mood swings	Yes ___	No ___	
Trouble sleeping	Yes ___	No ___	

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HEALTH BEHAVIORS CHECKLIST

Your doctor is interested in your overall health and will ask you about some of the behaviors you engage in. Don't be put off, this is routine. Try to answer honestly, your doctor is there to help you, not judge you. Here are some of the questions you may be asked:

Drugs:

1) **Do you smoke cigarettes or use tobacco products?** Yes __ No __

   If yes, age started? ____ **Packs per day?** ____

2) **Does anyone in your household smoke?** Yes __ No __

   If yes, who? ____

3) **Do you use any recreational drugs (including marijuana)?** Yes __ No __

Alcohol:

1) **Do you drink beer, wine, or liquor?** Yes __ No __

   If yes, how many alcoholic beverages do you consume in an average week?

   Less than 1: __ 1-3: __ 4-6: __ More than 6: __

Tanning:

1) **Do you lie in the sun to tan?** Yes __ No __
2) **Do you go to tanning studios?** Yes __ No __
3) **Do you use sunscreen?** Never __ Sometimes __ Always __

Exercising:

1) **Do you consider yourself physically active?** Yes __ No __
2) **How often do you exercise?**

   Never __ Less than once/week __ 1-2 times/week __ 3+ times/week __

3) **Are you able to keep up with your friends when doing physical activity?** Yes __ No __
4) **How do you perceive your current weight?** Underweight: __ Normal Weight: __ Overweight: __

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FEMALES ONLY: MENSTRUAL PERIOD CHECKLIST

This checklist helps prepare you for your annual physical or gynecologist appointment.

1) **Have you had a menstrual period during the past year?** Yes ___ No ___

   If yes, what was the date of your last menstrual period? ________________

   How often are your periods? Every ______ days

   How long do your periods last? ______ days

   Is your cycle: Regular ___ Irregular ___

   Is your menstrual flow: Light ___ Moderate ___ Heavy ___

   Are you menstruating today? Yes ___ No ___

   Today's date: _____________________________

2) **Have you had a pelvic exam, Pap smear, or breast exam in the past year?** Yes ___ No ___

   If yes, please list date and doctor: ____

3) **Do you take birth control pills or other hormones?** Yes ___ No ___

   If yes, please list: ____

4) **Do you perform breast self-examination?**

   No ___ Yes, occasionally ___ Yes, once a month ___