

Review of Systems

Please indicate the following N= a condition you have NOW P= a condition you have had in the PAST

Skin

Dry _____
Oily _____
Itching _____
Rashes _____
Hives _____
Fungal Infections _____
Bruise Easily _____
Slow Healing _____
Warts _____ Moles _____
Where? _____
How Many? _____
Nails Soft _____ Break _____

Head

Migraines _____ Headaches _____
Location of pain _____
Worse: Light ___ Noise ___ Odors ___
Head Injury _____
Describe _____
TMJ _____
Dizziness _____
Fainting _____
Seizures _____

Eyes

Vision Disturbance _____
Dryness _____ Tearing _____
Pain _____
Styes _____
Infections _____
Sensitive to Light _____

Ears

Discharge _____
Pain _____ Itch _____
Impaired Hearing _____
Ringing/noises _____

Nose

Seasonal Allergies _____
Drainage _____
Color: Clear ___ Yellow ___ Green ___
Texture: Runny _____ Thick _____
Post Nasal Drip _____
Stiffness _____
Sneezing _____
Sinus Infections _____
Nosebleeds _____

Throat/Neck

Pain in Throat _____
Glands Enlarged _____
Difficult Swallowing _____
Change in Voice _____
Clears Throat Often _____

Mouth

Dryness ___ Excessive Salivation ___
Tongue: Sore ___ Coated ___
Canker Sores _____

Respiratory

Pneumonia _____
Bronchitis _____
Cough _____
Spit up Blood _____
Asthma ___ Wheezing ___
Shortness of Breath _____
Positive TB Test Ever _____

Cardiovascular

Chest Pain _____
Heart Palpitations/Racing _____
Heart Disease _____
Murmur _____
High ___ Low ___ Blood Pressure _____
Varicose Veins _____
Phlebitis _____
Leg Pains ___ Cramps ___
Ankle Swelling _____
Cold Hands ___ Feet _____

Digestion

Bowel Movement _____
X per day: 1-2 ___ 2-3 ___ 3-4 ___ or
X per week: 1-2 ___ 2-3 ___ 3-4 ___
Size: Sm ___ Med ___ Lg ___
Color: Brown ___ Tan ___ Rust ___
Texture: Dry ___ Hard ___
Wet/Loose ___ Pellets ___
Stools with Mucous ___ Blood ___
Hemorrhoids _____
Bleeding ___ Painful ___ Itching ___
Fissures/Fistulas _____
Stool Incontinence _____
Bowel Disease _____
Liver/Gallbladder Disease _____
Ulcer _____
Heartburn _____
Bloating _____
Belching _____
Gas / Flatus _____
Nausea / Vomiting _____
Pains / Cramps _____

Urinary

Difficult Urination _____
Painful Urination _____
Incontinence/Dribbling _____
Blood in Urine _____
Bedwetting _____

Urinary (cont.)

Frequent Urination Day _____
Night _____
Frequent Bladder Infections _____

Muscular/Skeletal

Back Pain _____
Pain in Muscles/Joints/Bones _____
Stiffness/Swelling _____
Muscle Weakness/Tremor _____
Numbness/Tingling _____
Shooting Pain _____
Paralysis _____
Any Side Worse? R ___ L ___
Ever Broke Bones? _____
Which _____
Ever Sprain Joints? _____
Which _____

Energy in general (scale of 1-10)

1=worst 10=best _____
Best Time of day: AM or PM or _____
Worst time of day: AM or PM or _____

Sleep

Good ___ Bad ___
How many hours? _____
Wake Easily during night? Y/N
Why? _____ Time: _____
Difficulty Falling Asleep Y/N
Wake Refreshed? Y/N Grumpy? Y/N
Snore Y/N Talk Y/N
Grind Teeth Y/N Sleepwalk Y/N
Nightmares Y/N Dream a lot Y/N
Preferred Sleeping Position _____

Temperature

Sensitive to: Hot ___ Cold ___ Both ___
Prefer: Inside ___ Outside ___
Best Season ___ Worst Season ___

Perspiration

Sweat Easily Y/N
Sweat Excessively Y/N
Sweat Very Little Y/N

Appetite

Excessive ___ Good ___ Poor ___
Foods you crave strongly _____
Foods you dislike strongly _____
Prefer foods Hot ___ Warm ___ Cold ___
Thirst: Excessive ___ Good ___ Poor ___
Prefer drinks: Very Hot ___ Hot ___
Warm ___ Cold ___ Ice cold ___
Recent Weight Change Y/N

Women Only

Date of Last Pelvic Exam _____
 Date/Results of Last Pap Smear _____
 Ever Have an Abnormal Pap Smear? _____
 DES Exposure _____
 Sexually Transmitted Disease _____
 History of Sexual Abuse _____
 Frequent Yeast Infections _____
 Vaginal Discharge _____
 Age Period Began _____
 Regular Periods Yes ___ No ___ _____
 Flow: Heavy ___ Medium ___ Light ___ _____
 Length of Cycle ___ Days of Flow ___ _____
 Spotting _____
 Cramps _____
 PMS ___ Endometriosis ___ PID ___ _____
 Fibroids ___ Ovarian Cysts ___ _____
 Ever Used Birth Control Pills? _____
 How Long For? ___ How Long Ago? ___ _____
 Present Birth Control _____
 Change in Sex Drive _____
 Painful Intercourse _____
 Pregnancies (number) _____
 Childbirth (number) _____
 Complications _____
 Miscarriages (number) _____
 Abortions (number) _____
 Impaired Fertility _____
 Have You Had A Hysterectomy? _____
 Age at Menopause _____
 Vaginal Dryness _____
 Hot Flashes _____
 Do You Do Self Breast Exams? _____
 Mammograms (number) _____
 Date of Last Mammogram _____

Men Only

Date of Last Prostate Exam _____
 Prostate Enlargement _____
 Change in Force of Urine Stream _____
 Difficulty Starting Urine _____
 Do you do Self Testicular Exam _____
 History of Undescended Testes _____
 Pain / Lump in Scrotum _____
 Discharge From Penis _____
 Painful Intercourse _____
 Difficulty with Erections _____
 Change in Sex Drive _____
 Impaired Fertility _____
 Sexually Transmitted Diseases _____
 History of Sexual Abuse _____

Past History

Hospitalization(s): _____

Serious Illnesses and Injuries: _____

Date of Last Physical Exam _____
 Date of Last Blood Tests _____
 Date of Last Colonoscopy _____
 Date of Last DEXA (bone density test) _____

Personal Family History:

Please check the "yes" box next to each condition that applies to you or one of your family members. Please note whether the condition applies to you by writing the word "self" in the relation column or mother, father, sister, brother, aunt, uncle, grandmother or grandfather. Please indicate if the condition exists now (N) or in the past (P).

CONDITION	YES	RELATION	PAST (P) / NOW (N)
Alcoholism/Drug Addiction			
Allergies			
Alzheimer's			
Anemia			
Arthritis			
Asthma			
Birth Defects			
Cancer			
Type of Cancer?			
Depression			
Diabetes			
Eczema			
Epilepsy			
Headaches			
Heart Attack			
Heart Disease			
Hepatitis			
High Blood Pressure			
High Cholesterol			
Kidney Disease			
Learning Disability			
Mental Illness			
Mental Retardation			
Osteoporosis			
Stroke			
Suicide			
Thyroid Disease			
Tuberculosis			
Other			

Please list the names of your health care providers: _____

Do you have a specific spiritual practice? Y N If so, please describe it _____
Is there anything a health provider should know in relation to this? _____

Please list all prescription & over the counter medications that you are currently taking: **Medication, purpose, dose & date started.**

Medication/What is it for?	Dose	Date Started	Prescribed By

List vitamins, minerals, herbs, homeopathic remedies that you are currently taking: **Medication, purpose, dose & date started.**

Supplement/What is it for?	Dose	Date Started

Please list any severe or life-threatening allergies: _____

Please explain: _____

Personal Habits

Please indicate which substances, if any, pertain to you N= use NOW P= used in the PAST

Substance	N / P	How Much?	How Long?	Substance	N / P	How Much?	How Long?
Tobacco				Soda			
Coffee				Alcohol			
Black Tea				Recreational Drugs			

Do you have any dietary restrictions or follow a particular dietary regimen? If yes, please describe:

Do you exercise regularly? Yes _____ No _____ What type? _____