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 _____
Stuffiness _____
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?_____

_____