REVIEW OF SYSTEMS

Please check (√) the box for any conditions that you currently experience –

☐ For ***Current***, O for ***Past***

Blood/ Peripheral Vascular

C P

☐ O Anemia
☐ O Blood Clots
☐ O Cold hands/feet
☐ O Deep leg pain/cramps
☐ O Easy bleeding/ bruising
☐ O Gout
☐ O Thrombophlebitis
☐ O Varicose veins

Cardiovascular

☐ O Chest pain/pressure
☐ O Fainting/Light-headed
☐ O Heart Disease
☐ O High blood pressure
☐ O High cholesterol
☐ O Heartbeat, irregular
☐ O Heart murmur
☐ O Low blood pressure
☐ O Palpitations, fluttering
☐ O Rheumatic fever
☐ O Swelling in ankles/feet

Endocrine

☐ O Fatigue
☐ O Heat or cold intolerance
☐ O Hypo/hyperglycemia
☐ O Hypo/hyperthyroid
☐ O Increasing hunger
☐ O Increasing thirst
☐ O Seasonal depression

Neck

☐ O Goiter
☐ O Lumps
☐ O Pain or stiffness
☐ O Whiplash injury

Neurologic

C P

☐ O Loss of memory
☐ O Numbness or tingling
☐ O Paralysis
☐ O Seizures
☐ O Tremors or twitches

Mental/Emotional

☐ O Anxiety, nervousness
☐ O Poor memory
☐ O Depression
☐ O Concentration, difficult
☐ O Contemplate suicide
☐ O Critical of others
☐ O Critical of self
☐ O Experience loneliness
☐ O Mood swings
☐ O Tension, stress
☐ O Treatment for mental/emotional concerns

Head

☐ O Headaches
☐ O Head injury
☐ O Jaw; TMJ problems
☐ O Migraines

Nose and Sinuses

☐ O Frequent Colds
☐ O Hay fever
☐ O Loss of Smell
☐ O Loss of Balance
☐ O Nose bleeds
☐ O Red nose
☐ O Runny nose
☐ O Sinus problems
☐ O Stuffiness, congestion

Eyes

C P

☐ O Blurriness
☐ O Cataracts
☐ O Color blindness
☐ O Diminished night vision
☐ O Double vision
☐ O Dryness, excessive
☐ O Itchy eyes
☐ O Eye pain
☐ O Glasses or contacts
☐ O Glaucoma
☐ O Retinal detachment
☐ O Red Eyes
☐ O Spots in eyes
☐ O Swollen/painful eyes
☐ O Tearing, excessive

Ears

☐ O Dizziness/Vertigo
☐ O Earache
☐ O Ear infections
☐ O Ears, itchy
☐ O Hearing, impaired
☐ O Ringing, tinnitus
☐ O Wax, excessive

Mouth and Throat

☐ O Bad breath
☐ O Dental cavities/fillings
☐ O Dentures
☐ O Dry mouth
☐ O Frequent sore throat
☐ O Frequently clearing throat
☐ O Gagging/choking
☐ O Gum problems
☐ O Hoarseness
☐ O Metallic taste in mouth
☐ O Mouth sores
☐ O Saliva, excess
☐ O Sore throat
☐ O Sore tongue, lips
☐ O Teeth grinding

Respiratory
C P

☐ O Asthma
☐ O Bronchitis
☐ O Cough, chronic
☐ O Coughing with blood
☐ O Difficulty breathing
☐ O Emphysema
☐ O Pain on breathing
☐ O Pneumonia
☐ O Pleurisy
☐ O Shortness of breath
☐ O At night
☐ O Lying down
☐ O With exercise/exertion
☐ O Sleep apnea
☐ O Spitting up blood
☐ O Sputum
☐ O Wheezing

Urinary

☐ O Bed wetting
☐ O Blood in Urine
☐ O BPH
☐ O Frequency at night
☐ O Frequent infections
☐ O Increased frequency
☐ O Inability to hold urine
☐ O Kidney stones
☐ O Kidney, back pain
☐ O Low force of urine
☐ O Pain with urination
☐ O Urine retention
☐ O Urgency with urination

Immune

☐ O Chronic Fatigue Syndrome
☐ O Chronic infections
☐ O Chronically swollen glands
☐ O Slow wound healing
☐ O Swollen glands

Gastrointestinal
C P

☐ O Abdominal pain, cramps
☐ O Alternating diarrhea/constipation
☐ O Belching
☐ O Blood in stool/stool appearing black
☐ O Change in stool
☐ O Bulimia
☐ O Change in appetite
☐ O Change in thirst
☐ O Colitis
☐ O Constipation
☐ O Cramps
☐ O Diarrhea
☐ O Fatigue after eating
☐ O Food intolerances
☐ O Flatulence/gas
☐ O Gallbladder disease
☐ O Heartburn/Acid Reflux
☐ O Hemorrhoids
☐ O Hepatitis
☐ O Indigestion
☐ O Itchy/Burning Anus
☐ O Jaundice
☐ O Liver disease
☐ O Mucous in stools
☐ O Nausea
☐ O Pain in rectum
☐ O Painful stool
☐ O Parasites, diagnosed
☐ O Rectal bleeding
☐ O Reflux
☐ O Stomach pain
☐ O Trouble swallowing
☐ O Ulcers
☐ O Vomiting

Musculoskeletal
C P

☐ O Arch supports/heel lifts
☐ O Arthritis
☐ O Back pain
☐ O Broken bones
☐ O Joint pain or stiffness
☐ O Joint swelling
☐ O Muscle pain
☐ O Muscle spasms/cramps
☐ O Muscle weakness, tiredness
☐ O Osteoporosis/osteopenia
☐ O Restless Leg Syndrome
☐ O Sciatica

Skin

☐ O Acne
☐ O Boils
☐ O Cancer
☐ O Color change
☐ O Dry Skin/Scalp
☐ O Eczema
☐ O Flushing/hot flashes
☐ O Fungal Infections
☐ O Hair loss
☐ O Hives
☐ O Itching
☐ O Lumps
☐ O Night sweats
☐ O Moles
☐ O Psoriasis
☐ O Rashes
☐ O Rosacea
☐ O Skin Tag
☐ O Ulcers

General

C P

☐ O Allergies

☐ O Cancer

☐ O Cravings _____

☐ O Diabetes

☐ O Digestion Issues

☐ O Dream disturbed sleep

☐ O Easily Stressed

☐ O Edema

☐ O Experience High Stress

☐ O Fever

☐ O Generally feel cold

☐ O Generally feel hot

☐ O Insomnia

☐ O Recent weight changes

☐ O Stroke

☐ O Trouble Concentrating

☐ O Tuberculosis

☐ O Other _____

MALE REPRODUCTIVE

Please check (√) the box for any which apply to you:

☐ O Birth control, type?

_____

☐ O BPH

☐ O Discharge or sores

☐ O Ejaculation concerns

☐ O Fertility concerns

☐ O Hernias

☐ O Impotence

☐ O Low Libido

☐ O Penile discharge

☐ O Penile sores

☐ O Prostate disease

☐ O Sexually active

☐ O Sexual difficulties

☐ O Sexually transmitted infection(s) _____

☐ O Testicular masses

☐ O Testicular pain

REPRODUCTIVE, FEMALE

Age of first menses _____

Avg. length of blood flow ____ (days)

Number of days between menstrual cycles _____ (days)

Date of last menstrual period

_____

Are cycles regular? Y N

Are you pregnant? Y N

Age of last period (if menopausal)

_____

Mother's age at menopause

_____

Date of last annual exam/PAP

_____

Do you do self-breast exam? Y N

How often? _____

Please specify number of:

Pregnancies _____

Live Births _____

Miscarriages _____

Abortions _____

Please check (√) the box for any which apply to you:

☐ O Abnormal PAP

☐ O Birth control, type?

_____

☐ O Bleeding between cycles

☐ O Breast lumps, fibrocystic changes

☐ O Breast pain or discomfort

☐ O Cervical dysplasia

☐ O Clotting

☐ O Cramping with menses

☐ O DES exposure

☐ O Difficulty getting pregnant

☐ O Endometriosis

☐ O Genital warts

☐ O Heavy menstrual flow

☐ O Hormone replacement therapy

☐ O Hysterectomy, oophorectomy

☐ O Hysterectomy, ovaries intact

☐ O Increased libido

☐ O Decreased libido

☐ O Irregular cycles

☐ O Menopausal symptoms

☐ O Nipple discharge

☐ O Other

_____

☐ O Ovarian cysts/PCOS

☐ O Painful intercourse

☐ O Painful periods

☐ O Premature births

☐ O Premenstrual Syndrome (PMS)

☐ O Scanty menstrual flow

☐ O Spotting between periods

☐ O Sexual difficulties

☐ O Sexually active

☐ O Sexually transmitted infection

_____

☐ O Uterine fibroids

☐ O Vaginal discharge/odor