Patient Name___________________________

Review of Systems

Have you had or do you now have any of the following symptoms or conditions?
Please indicate **"C" if you are *currently* experiencing** the particular symptom or condition and
"P" if you have *previously* experienced the particular symptom or condition. If neither, leave blank.

HEAD
Headaches ____________
Sinus problems ____________
Hearing loss ____________
Ringing in ears ____________
Vision changes ____________
Dental problems ____________
Ear infections ____________

RESPIRATORY
Asthma ____________
Bronchitis ____________
Pneumonia ____________
Chronic cough ____________

CARDIOVASCULAR
Hypertension ____________
High cholesterol ____________
Heart disease ____________
Arrhythmia ____________
Poor circulation ____________
Clotting disorder ____________
Heart attack ____________
Stroke ____________
Varicose veins ____________

GASTROINTESTINAL
Nausea/vomiting ____________
Reflux/heartburn ____________
Gas/bloating ____________
Diarrhea ____________
Constipation ____________
Colitis / Crohn's ____________
Gallbladder ____________
Diverticulitis ____________

NERVOUS SYSTEM
Alzheimer's ____________
Epilepsy ____________
Parkinson's ____________
Multiple sclerosis ____________
Restless legs

GENITOURINARY
Kidney stones ____________
Kidney infection ____________
Urinary tract infection ____________

FEMALE REPRODUCTIVE
Irregular menses ____________
Heavy bleeding ____________
Endometriosis ____________
Fibroids/ovarian cysts ____________
PCOS ____________
PMS ____________
Fibrocystic breasts ____________
Vaginal infections ____________
Menopausal symptoms ____________
Decreased libido ____________
Infertility ____________
Date of LMP ____________

MALE REPRODUCTIVE
Decreased libido ____________
Enlarged prostate ____________
Infertility ____________
Infections ____________
Erectile dysfunction ____________

ENDOCRINE
Chronic fatigue ____________
Diabetes ____________
Thyroid disorder ____________
Weight control issues ____________

BLOOD, IMMUNE, INFECTIONS
Autoimmune disease ____________
Hepatitis ____________
Lyme Disease ____________
HIV ____________
Anemia ____________

CANCER
Type/Location ____________
Date Diagnosed ____________

MUSCULOSKELETAL
Neck pain/stiffness ____________
Low back pain ____________
Joint pain ____________
Osteoarthritis ____________
Rheumatoid arthritis ____________
Gout ____________
Carpal tunnel ____________
Muscle aches ____________
Tendonitis ____________

SKIN & HAIR
Acne ____________
Dry and itchy ____________
Rashes/Hives ____________
Eczema/Psoriasis ____________
Easy brusiing ____________
Hair loss ____________
Abnormal hair growth ____________

MENTAL/EMOTIONAL/OTHER
Depression ____________
Anxiety ____________
Poor memory ____________
Poor energy ____________
High stress ____________
Eating disorder ____________
Alcoholism ____________
ADD/ADHD ____________
Other ____________

SLEEP
Insomnia ____________
Trouble falling asleep ____________
Restlessness ____________
Nightmares ____________
Hours per night ____________
Difficulty arising ____________
Sleep quality:
Poor ____________
Fair ____________
Good ____________

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Patient Name____________________________

Family Health History

Has anyone in your family (including parents, grandparents, brothers, sisters or children) had any of the following conditions? Please fill out to the best of your knowledge.

Condition or disease	***Y / N***	***Relationship***	***Living or Deceased***
Alcoholism			
Anemia			
Arthritis			
Autoimmune disease			
Bleeding / clotting disorders			
Cancer (specify type):			
Breast			
Colon			
Lung			
Ovarian			
Prostate			
Skin			
Other			
Depression / anxiety			
Diabetes			
Heart attack / angina			
Heart disease			
Hepatitis			
High blood pressure			
High cholesterol			
HIV / AIDS			
Kidney disease			
Mental illness			
Neurological disease			
Stroke			
Thyroid disease			
Other (please specify):			

For Women Only

Menstrual cycle

Age of onset: ____________________

Date of LMP: ____________________

Cycle length: ____________________

PMS? Describe: ____________________

____

____

____

____

Obstetrical / Gynecological

Are you currently pregnant? ____________________

Total # of pregnancies ____________________

# of full term deliveries ____________________

Miscarriages / abortions? ____________________

Any pregnancy complications? ____________________

Current form of birth control ____________________

Date of last PAP smear ____________________

History of abnormal PAPs? ____________________

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