

Review of Systems

Check the appropriate box: C for current conditions, P for Past conditions

General symptoms		Varicose veins	C <input type="checkbox"/> P <input type="checkbox"/>	Numbness, tingling	C <input type="checkbox"/> P <input type="checkbox"/>
Dizziness	C <input type="checkbox"/> P <input type="checkbox"/>	Ankle swelling	C <input type="checkbox"/> P <input type="checkbox"/>	Changes in sensation	C <input type="checkbox"/> P <input type="checkbox"/>
Fainting	C <input type="checkbox"/> P <input type="checkbox"/>	Poor circulation	C <input type="checkbox"/> P <input type="checkbox"/>	Poor memory	C <input type="checkbox"/> P <input type="checkbox"/>
Sweats	C <input type="checkbox"/> P <input type="checkbox"/>			Change in taste	C <input type="checkbox"/> P <input type="checkbox"/>
Cold hands / feet	C <input type="checkbox"/> P <input type="checkbox"/>	Gastrointestinal		Gum disease	C <input type="checkbox"/> P <input type="checkbox"/>
Insomnia	C <input type="checkbox"/> P <input type="checkbox"/>	Trouble swallowing	C <input type="checkbox"/> P <input type="checkbox"/>	Cavities	C <input type="checkbox"/> P <input type="checkbox"/>
Weight loss	C <input type="checkbox"/> P <input type="checkbox"/>	Poor digestion	C <input type="checkbox"/> P <input type="checkbox"/>	Hoarseness	C <input type="checkbox"/> P <input type="checkbox"/>
Weight gain	C <input type="checkbox"/> P <input type="checkbox"/>	Heartburn	C <input type="checkbox"/> P <input type="checkbox"/>	Difficulty swallowing	C <input type="checkbox"/> P <input type="checkbox"/>
Fatigue	C <input type="checkbox"/> P <input type="checkbox"/>	Change in thirst	C <input type="checkbox"/> P <input type="checkbox"/>	Sore throat	C <input type="checkbox"/> P <input type="checkbox"/>
Alcoholism	C <input type="checkbox"/> P <input type="checkbox"/>	Change in appetite	C <input type="checkbox"/> P <input type="checkbox"/>	Strep throat	C <input type="checkbox"/> P <input type="checkbox"/>
Anemia	C <input type="checkbox"/> P <input type="checkbox"/>	Change in weight	C <input type="checkbox"/> P <input type="checkbox"/>	Swollen glands	C <input type="checkbox"/> P <input type="checkbox"/>
Nutrient deficiency	C <input type="checkbox"/> P <input type="checkbox"/>	Belching or gas	C <input type="checkbox"/> P <input type="checkbox"/>	Thyroid imbalance	C <input type="checkbox"/> P <input type="checkbox"/>
Weak/brittle nails	C <input type="checkbox"/> P <input type="checkbox"/>	Nausea / Vomiting	C <input type="checkbox"/> P <input type="checkbox"/>	Loss of hair	C <input type="checkbox"/> P <input type="checkbox"/>
Head & Neck		Abdominal pain	C <input type="checkbox"/> P <input type="checkbox"/>	Dry/oily hair	C <input type="checkbox"/> P <input type="checkbox"/>
Headaches	C <input type="checkbox"/> P <input type="checkbox"/>			Premature grey hair	C <input type="checkbox"/> P <input type="checkbox"/>
Head injury	C <input type="checkbox"/> P <input type="checkbox"/>	Skin		Thinning eyebrows	C <input type="checkbox"/> P <input type="checkbox"/>
TMJ pain	C <input type="checkbox"/> P <input type="checkbox"/>	Itching	C <input type="checkbox"/> P <input type="checkbox"/>	Excess hair growth	C <input type="checkbox"/> P <input type="checkbox"/>
Poor vision	C <input type="checkbox"/> P <input type="checkbox"/>	Rashes, Eczema	C <input type="checkbox"/> P <input type="checkbox"/>		
Itchy/red eyes	C <input type="checkbox"/> P <input type="checkbox"/>	Psoriasis	C <input type="checkbox"/> P <input type="checkbox"/>	Respiratory	
Circles under eyes	C <input type="checkbox"/> P <input type="checkbox"/>	Acne	C <input type="checkbox"/> P <input type="checkbox"/>	Cough	C <input type="checkbox"/> P <input type="checkbox"/>
Earaches/ infection	C <input type="checkbox"/> P <input type="checkbox"/>	Dry skin	C <input type="checkbox"/> P <input type="checkbox"/>	Shortness of breath	C <input type="checkbox"/> P <input type="checkbox"/>
Hearing loss	C <input type="checkbox"/> P <input type="checkbox"/>	Changes in mole	C <input type="checkbox"/> P <input type="checkbox"/>	Wheezing	C <input type="checkbox"/> P <input type="checkbox"/>
ringing in ears	C <input type="checkbox"/> P <input type="checkbox"/>	Easy bruising	C <input type="checkbox"/> P <input type="checkbox"/>	Asthma	C <input type="checkbox"/> P <input type="checkbox"/>
Sinus problems	C <input type="checkbox"/> P <input type="checkbox"/>	Hives	C <input type="checkbox"/> P <input type="checkbox"/>	Difficulty breathing	C <input type="checkbox"/> P <input type="checkbox"/>
Loss of smell	C <input type="checkbox"/> P <input type="checkbox"/>	Warts	C <input type="checkbox"/> P <input type="checkbox"/>	Sputum	C <input type="checkbox"/> P <input type="checkbox"/>
				Allergies	C <input type="checkbox"/> P <input type="checkbox"/>
Cardiovascular		Muscles and Joints		Pneumonia	C <input type="checkbox"/> P <input type="checkbox"/>
High blood pressure	C <input type="checkbox"/> P <input type="checkbox"/>	Stiff neck	C <input type="checkbox"/> P <input type="checkbox"/>		
Low blood pressure	C <input type="checkbox"/> P <input type="checkbox"/>	Backache/tension	C <input type="checkbox"/> P <input type="checkbox"/>	Infections / Illnesses	
Bleeding disorders	C <input type="checkbox"/> P <input type="checkbox"/>	Swollen joints	C <input type="checkbox"/> P <input type="checkbox"/>	Frequent colds, flus	C <input type="checkbox"/> P <input type="checkbox"/>
Anemia	C <input type="checkbox"/> P <input type="checkbox"/>	Joint pain	C <input type="checkbox"/> P <input type="checkbox"/>	Cold sores	C <input type="checkbox"/> P <input type="checkbox"/>
Chest pain	C <input type="checkbox"/> P <input type="checkbox"/>	Arthritis	C <input type="checkbox"/> P <input type="checkbox"/>	Mono	C <input type="checkbox"/> P <input type="checkbox"/>
Angina	C <input type="checkbox"/> P <input type="checkbox"/>	Weakness	C <input type="checkbox"/> P <input type="checkbox"/>	Genital herpes	C <input type="checkbox"/> P <input type="checkbox"/>
Murmurs	C <input type="checkbox"/> P <input type="checkbox"/>	Muscle spasms	C <input type="checkbox"/> P <input type="checkbox"/>	Hepatitis	C <input type="checkbox"/> P <input type="checkbox"/>
Palpitations	C <input type="checkbox"/> P <input type="checkbox"/>	Broken bones	C <input type="checkbox"/> P <input type="checkbox"/>	Shingles	C <input type="checkbox"/> P <input type="checkbox"/>
Heart disease	C <input type="checkbox"/> P <input type="checkbox"/>	Gout	C <input type="checkbox"/> P <input type="checkbox"/>	Tuberculosis	C <input type="checkbox"/> P <input type="checkbox"/>
Stroke	C <input type="checkbox"/> P <input type="checkbox"/>			STI	C <input type="checkbox"/> P <input type="checkbox"/>
Artery hardening	C <input type="checkbox"/> P <input type="checkbox"/>	Neurological		HIV / AIDS	C <input type="checkbox"/> P <input type="checkbox"/>

Cancer C P
 Constipation C P
 Diarrhea C P
 Blood in stool C P
 Black, tarry stool C P
 Hemorrhoids C P
 Parasites / yeast C P
 Liver concerns C P
 Jaundice C P
 Gall bladder trouble C P
 Ulcer C P
 Hernias C P
 Diabetes C P
 Food sensitivities C P
 Food cravings C P

Genitorurinary

Pain on urination C P
 Blood in the urine C P
 Kidney stones C P
 Urgency C P
 Increased frequency C P
 Hesitancy C P
 Bladder infections C P

Mental/emotional

Severe stress C P
 Anxiety C P
 Depression C P
 Mood changes C P
 Mental illness C P
 Child abuse C P
 Physical abuse C P
 Emotional abuse C P
 Sexual abuse C P
 Seizures C P
 Paralysis C P
 Loss of balance C P
 Speech problems C P

Men's Health

Testicular masses C P
 Testicular pain C P
 Prostate trouble C P
 Discharge or sores C P
 Sexual difficulties C P

Women's Health

Painful menses C P
 Painful intercourse C P
 Heavy menses C P

Irregular cycle C P
 Hot flashes C P
 Cramps or backache C P
 Vaginal discharge C P
 Vaginal itch C P
 Ovary/ uterine pain C P
 Endometriosis C P
 Fibroids C P
 Breast tenderness C P
 Lumps in the breast C P
 Nipple discharge C P
 Post-partum depression C P

Do you do self breast exams?

Yes No

Age of menarche _____
 Age at menopause _____
 # of pregnancies _____
 # of live births _____
 # of miscarriages _____
 # of abortions _____
 # of vaginal _____
 # of C-sections _____