REVIEW OF SYSTEMS

Please checkmark any of the following conditions you currently have (C) or had in the past (P).

Mental Emotional

C	P		C	P	
□	□	Abuse	□	□	Mental Illness
□	□	Anxiety or nervousness	□	□	Mood swings
□	□	Easily anger	□	□	Panic attacks
□	□	Indecision	□	□	Phobias
□	□	Irritability	□	□	Prolonged sadness or grief
□	□	Memory problems			

What were the four most stressful events in your life? Are any of these still affecting you?

1._____
2._____
3._____
4._____

Has there been an event or sickness that you have never fully recovered from?

_____

Endocrine

C	P		C	P	
□	□	change in weight	□	□	Generally feel cold
□	□	Sluggish after eating	□	□	Hypolycemia (low blood sugar)
□	□	Generally feel hot	□	□	Mental dullness

Rate your energy level between 1 and 10 1(extreme fatigue) 2 3 4 5 6 7 8 9 10(vital)
Rate your stress level 1(relaxed) 2 3 4 5 6 7 8 9 10(very stressed)

At what time of day is your energy the best? _____
At what time of day is your energy the worst? _____

How many hours of sleep do you get a night? _____
Do you wake feeling stressed? _____

Immune

C	P		C	P	
□	□	Chronic infections	□	□	Swollen glands or lymph nodes
□	□	Frequent antibiotics	□	□	Shingles
□	□	Frequent colds and flues	□	□	Slow wound healing
□	□	Cold sores	□	□	Frequent sore throat

Neurologic

C	P		C	P	
□	□	Paralysis	□	□	Loss of memory
□	□	Numbness	□	□	Loss of balance
□	□	Muscle weakness	□	□	Vertigo or dizziness
□	□	Tingling			

Skin, Hair and Nails

C	P		C	P	
□	□	Rashes	□	□	Dry skin
□	□	Lumps or abscesses	□	□	Hair loss
□	□	Excessive perspiration	□	□	Change in the size, shape or colour of a mole or freckle
□	□	Itching	□	□	Night sweats
□	□	Change in colour	□	□	Brittle nails
□	□	Strong body odour	□	□	Warts

How many times have you had a sunburn? _____

Head, Ears, Eyes, Nose, Throat

C	P		C	P		C	P	
□	□	Headaches	□	□	Hormones	□	□	Itchy ear canal
□	□	Cataracts	□	□	Far sighted			
□	□	Colour blindness	□	□	Jaw pain or clicking			
□	□	Nose bleeds	□	□	Excessive tearing			
□	□	Gum problems	□	□	Earaches			
□	□	Poor night vision	□	□	Post nasal drip			
□	□	Migraine headaches	□	□	Teeth grinding			
□	□	Visual disturbances	□	□	Runny nose			
□	□	Ringing in ears	□	□	Near sighted			
□	□	Poor sense of smell	□	□	Dry eyes			
			□	□	Impaired hearing			
			□	□	Loss of smell			

Respiratory System

C	P		C	P	
□	□	Chronic cough	□	□	Cough up blood
□	□	Shortness of breath lying down	□	□	Shortness of breath during the day
□	□	Chronic phlegm			
□	□	Pain while breathing	□	□	Wheezing

Cardiovascular System

P	C		P	C	
□	□	Chest pain	□	□	Easy bleeding or bruising
□	□	Hemorrhoids	□	□	Cold hands and feet
□	□	You feel dizzy when you stand up quickly	□	□	Swelling of the ankles
			□	□	Heaviness or pain in legs
□	□	Fainting	□	□	Varicose veins
□	□	Heart palpitations	□	□	Heart murmurs

Gastrointestinal System

P	C		P	C		P	C	
□	□	Trouble swallowing	□	□	Bloating	□	□	Undigested food in stool
□	□	Nausea	□	□	Stomach cramps or pain	□	□	Change in appetite
□	□	Blood in stool or on tissue	□	□	Itching around rectum	□	□	Burping
□	□	Mucous in stool	□	□	Change in thirst	□	□	Diarrhea or loose stool
□	□	Stool floats in bowl	□	□	Gas			
			□	□	Constipation			
□	□	Heartburn	□	□	Black stool			

How often do you have a bowel? _____

Have you ever traveled to a third world country? If so, for how long?

_____

Have you ever had parasite that you are aware of? _____

Musculoskeletal

P	C		P	C	
□	□	Easy bleeding or bruising	□	□	Thrombophlebitis
□	□	Deep leg pain			
□	□	Varicose veins			
□	□	Anemia			
□	□	Cold hands/feet			

Urinary

P	C		P	C	
□	□	Pain or urination	□	□	Increased frequency
□	□	Frequent bladder infections	□	□	Awaken to urinate
□	□	Strong urine odour	□	□	Must strain to urinate
□	□	Inability to hold urine	□	□	Pain on urination
□	□	Kidney infections			

Male Reproductive

P	C		P	C	
□	□	Hernia	□	□	Testicular pain
□	□	Discharge or sores	□	□	Impotence
□	□	Testicular mass	□	□	Low sex drive
□	□	Sexual difficulties	□	□	Prostate condition
□	□	Sexually Transmitted Disease			

Female Reproduction/Breasts

Age of first menses _____
Duration of menses _____
Date of last annual exam/PAP (M/D/Y)_____

Length of cycle _____
Age of last menses (if menopausal) _____

P	C		P	C		P	C	
□	□	Irregular cycles	□	□	Nipple discharge	□	□	Difficulty conceiving
□	□	Bleeding between cycles	□	□	Abnormal PAP			
□	□	Cramping with menses	□	□	Cervical Dysplasia			
□	□	Premenstrual Syndrome	□	□	Endometriosis			
□	□	Clotting	□	□	Ovarian cysts			
□	□	Heavy or excessive flow	□	□	Uterine fibroids			
□	□	Vaginal discharge	□	□	Sexually active			
□	□	Menopausal symptoms	□	□	Painful intercourse			
□	□	Breast lumps	□	□	Sexual difficulties			
□	□	Breast pain/tenderness	□	□	Sexually Transmitted Disease			
			□	□	Birth Control: type_____			

Family Health History

Relative	Age if alive	Age at death	Ailments
Mother			
Father			
Sisters			
Brothers			
Maternal Grandmother			
Maternal Grandmother			
Maternal Aunts/Uncles			
Paternal Grandmother			
Paternal Grandfather			
Paternal Aunt/Uncle			