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
Chronic infection
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

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			

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 _____

Any pregnancy complications? _____

Current form of birth control _____

Date of last PAP smear _____

History of abnormal PAPs? _____

_____