

REVIEW OF SYSTEMS

Patient Name: _____

Have you ever been diagnosed with or experienced any of the following (check all that apply):

Infectious Diseases

- Chicken Pox
- Hepatitis
- Measles
- Mumps
- Polio
- Rheumatic Fever
- Small Pox
- Scarlet Fever
- Tuberculosis
- Whooping Cough
- Venereal Diseases
- HIV/AIDS

Musculo-Skeletal

- Arthritis
- Headaches
- Neck Pain
- Mid Back Pain
- Low Back Pain
- Shoulder Pain
- Arm Pain
- Thigh Pain
- Leg Pain
- Foot Pain
- Clicking Jaw
- Walking Problems
- Rheumatoid Arth.
- Fibromyalgia
- Osteoarthritis

Lifestyle / Self-Care Issues

- Have you ever smoked cigarettes?..... Yes No
 If yes, _____ packs per day, Smoked for _____ years
- Are you still smoking..... Yes No
- Do you drink caffinated beverages?..... Yes No
 If yes, _____ cups, cans, etc./day
- Do you drink alcohol?..... Yes No
 if yes, _____ number of drinks / week _____
- Previous drug/alcohol problems?..... Yes No
- Do you manage stress well?..... Yes No Need Help
- Do you exercise regularly?..... Yes No
 Type, Frequency _____
- Do you sleep soundly?..... Yes No
- Are you satisfied with your social live..... Yes No
- Does your diet healthy enough?..... Y N Not Sure Need Help

Past Medical History (circle)

- | | | |
|----------------|------------------|---------------------|
| Aids, HIV | Alcoholism | Allergy |
| Arthritis | Asthma | Cancer |
| Cholesterol | Depression | Diabetes |
| Epilepsy | Heard Disease | Hepatitis |
| Herniated Disk | Pacemaker | Pinched Nerve |
| Prostate | Scarlet Fever | Stroke |
| Suicide | Thyroid | Tuberculosis |
| Tumors | Verereal Disease | High Blood Pressure |

Other Illness _____

Surgery _____

Other Injuries/Accidents _____

Nervous System

- Attention Deficit
- Confusion
- Dizziness
- Epilepsy
- Fainting
- Forgetfulness
- Hyperactivity
- Mental Disorder
- Nervousness
- Numbness
- Paralysis
- Tingling
- Stress
- Vertigo

Cardiovascular

- Angina
- Chest Pain
- Hypertension
- Hypotension
- Lung Congestion
- Shortness of Breath
- Heart Problems
- Heart Disease
- Palpitations
- Stroke
- Ankle Swelling
- Varicose Veins

Ears, Eyes, Nose, Throat

- Ear Infections
- Dental Problems
- Halitosis
- Hearing Difficulties
- Sinus Congestion
- Sore Throat
- Vision Problems

Respiratory System

- Allergies
- Asthma
- Bronchitis
- Influenza
- Pleurisy
- Pneumonia

Urogenital

- Bladder Infections
- Excessive Urination
- Difficult Urination
- Kidney Problems
- Incontinence
- Menstrual Cramping
- Menstrual Irregularity
- Painful Urination
- Sexual Dysfunction
- Prostate Problems
- Vaginal Infections
- Vaginal Pain

Gastro-Intestinal

- Abdominal Cramps
- Anemia
- Acid Indigestion
- Bloody stool
- Coughing Up Blood
- Constipation
- Crohn's Disease
- Diabetes
- Diarrhea
- Eating Disorder
- Excessive Appetite
- Gall Bladder Problems
- Liver Problems
- Irritable Bowel
- Nausea
- Poor Appetite
- Thyroid Problems
- Ulcers
- Ulcerative Colitis

Other

- Alcoholism
- Alzheimer's
- Broken Bones
- Cancer
- Fatigue
- Concussion
- Muscular Dystrophy
- Parkinson's

Diet Habits and Typical Daily Intake

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Fluids: cups of water: _____ Other Fluids: _____

Current Medications

Dosage Times/Day

_____	_____	_____
_____	_____	_____
_____	_____	_____

Current Herbs / Vitamins

Dosage Times/Day

_____	_____	_____
_____	_____	_____

Social History:

Education Level Completed: _____

Living Arrangement: _____

Children (*list ages*): _____

Major stress in last six months?: _____

Your Health Care Team

Family Physician: _____ Phone: _____

Other Specialist: _____ Phone: _____

Have you ever seen:

Chiropractor Name _____

Acupuncture Name _____

Massage Therapist Name _____