

Review of Systems

Name:

Date of birth:

Today's Date:

YOUR HEALTHCARE TEAM

Please list all healthcare practitioners you are currently being treated by:

Name	Type of practitioner (eg. family doctor, counselor, acupuncturist, RMT)	Phone and fax number
		Phone: Fax:
		Phone: Fax:
		Phone: Fax:

Please List your chief complaints in order of importance:

1) _____

2) _____

3) _____

4) _____

Additional comments about chief complaints:

MEDICATION YOU ARE CURRENTLY TAKING
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Name/ brand/ type	Dose	For what condition	Since when

PAST MEDICATION			
Name/ brand/ type	Dose	For what condition	For how long?

NATURAL HEALTH PRODUCTS YOU ARE CURRENTLY TAKING			
Product/ brand	Dose	Reason	Since when

MEDICAL HISTORY		
Have you ever been hospitalized/ had surgery?		
Date:	Reason	Problems experienced since

For each of the following items, please write (N) for conditions you have never experienced, (P) for conditions you have experienced in the past or (C) for conditions you are currently experiencing. Where several conditions are listed together please circle the condition that pertains to you.

SKIN			
Rashes/ eczema/ hives/ itching		Hair changes (colour, shine, loss)	
Acne/ boils/ bumps/ lumps		Temperature	
Excess dryness/ moistness		Night sweats	
Colour change/ mole changes		Skin ulcers	
Nail changes (shape, strength, thickness)		Skin cancer	
Have you ever had a complete skin exam?		Date:	
HEAD			
Headache		Problems with jaw joint? (TMJ)	
Head injury			
Dizziness			
Have you ever had an MRI, CT Scan etc?		Date:	Result:
EYES			
Impaired vision/ double vision/ blurring		Floaters	
Glasses/ contact lenses		Sensitive to sunlight	
Eye pain		Itching/ discharge	
Excess tearing/ dryness		Blindspot	
Glaucoma/ cataracts		Redness	
When did you last visit your eye doctor?			
Do you use eyedrops, artificial tears or other eye products?			

EARS			
ringing		Discharge	
Impaired hearing/ hearing aid		Excess ear wax	
Earache/ Infection		Ruptured ear drum	
Ear tubes		Do you use Q-tips?	
NOSE AND SINUSES			
Frequent colds/ stuffiness		Sinus problems	
Nose bleeds		Sensitive to smells	
Allergies/ hay fever		Change in ability to taste	
MOUTH, THROAT AND NECK			
Frequent sore throat/ hoarseness		Lumps/ swollen glands in neck	
Sore tongue/ mouth		Thyroid problems/ goiter	
Gum problems/ bleeding		Pain/ stiffness in neck	
Dry mouth			
Dental cavities		How many? What type of filling?	
When was your last visit to the dentist?			
How often do you brush?		How often do you floss?	
RESPIRATORY			
Cough/ wheezing		Shortness of breath when lying down	
Sputum/ mucous		Bronchitis	
Spitting up blood		Pneumonia	
Asthma		Pleurisy (inflammation of lungs)	
Pain/ difficulty on breathing		Emphysema	
Shortness of breath		Tuberculosis	
Shortness of breath at night/ apnea			
Do you smoke?		How long? How many?	
Tuberculin test		Date: Test result:	
Date of last chest x-ray			
CARDIOVASCULAR			
Heart disease		High blood cholesterol	
Angina/ chest pain		Rheumatic fever	
High blood pressure		Swelling in ankles	
Murmur/ irregular heart beat/ palpitations/ fluttering		Cyanosis (blueness)	
Past ECG		Date: Result:	
Other heart tests/ stress test			
BREASTS			
Lumps/ skin puckering		Nipple discharge/ changes	
Pain or tenderness		Implants/ reduction/ surgery	
Have you ever breast fed? Any problems breast feeding?			
Do you do self exams?		How often?	
Is there is history of breast cancer in your family?			
GASTROINTESTINAL			
Heartburn/ acid reflux		Belching/ passing gas	
Trouble swallowing		Offensive breath/ bad taste in mouth	
Changes in appetite/ thirst		Bloating/ abdominal pain	

Nausea/ vomiting		Yellow skin	
Vomiting blood		Hernia	
How often are your bowel movements?		Is this a change?	
Blood/ mucous/ undigested food in stool		Indigestion	
Liver disease/ hepatitis		Diarrhea/ constipation	
Gall bladder disease/ stones/ removal		Rectal bleeding/ hemorrhoids	
Ulcer		Black tarry stool	
Food allergies/ sensitivities		Please list offending foods:	
How is your appetite?			
a) I'm hungry all the time and can't seem to satisfy my hunger (regular meals aren't enough)			
b) It seems normal to me (eat regular meals)			
c) I'm not often hungry and I sometimes have to force myself to eat (can easily skip meals)			
How is your thirst?			
a) I've noticed an increased thirst that I can't satisfy (drink a lot of fluids throughout the day)			
b) It seems normal to me (drink fluids throughout the day)			
c) I'm not usually thirsty (I forget to drink fluids)			
What food restrictions do you have?			
Do you have any food cravings?			
Please list the foods that you crave most:		What affects your food cravings?	
How much water do you drink? (do not include caffeinated drinks or alcohol)			
Do you drink tea, coffee, or pop?		How much?	
Do you drink alcohol?		What kind?	How much?
24 hour food recall: Please write down what you typically eat in a day (include time and amounts):			
Have you had any gastrointestinal surgeries?			
Do you take antacids/ special digestive aids?			
Is there a history of colorectal cancer in you family?			
URINARY			
Pain/ pressure on urination		Inability to hold urine/ incontinent	
Blood in urine		Frequent urinary infections	
Increased frequency		Kidney problems (stones, infections)	
Frequency at night		Urgency/ hesitancy	
MALE REPRODUCTIVE			
Testicular masses/ pain		Prostate problems	
Do you do testicular self-exams?			

When was last prostate exam?		
Any sexual difficulties/ erectile dysfunction		
Discharge/ sores		
Problems with sperm/ conceiving		
FEMALE REPRODUCTIVE		
Age of first period		
Average number of days of bleeding		
Length of cycle		
Bleeding between periods		PMS/ painful periods
Irregular cycles		Excess flow
Sexual difficulties/ pain during intercourse		Hormonal birth control
Number of pregnancies		
Number of miscarriages/ abortions		
Number of live births		
Difficulties conceiving		
Menopause		Age:
Hot flashes/ dryness/ other problems with menopause		Cervical cancer
Hormonal therapy for menopause		
Vaginal itching/ redness		Vaginal discharge (circle those that apply) a) clear fluid b) white c) thick or sticky d) greenish/ yellow e) grey f) strong odour (fishy)
Date of last PAP		Result
MALE AND FEMALE SEXUAL		
Sexually transmitted disease(s)		Since when?
MUSCULOSKELETAL		
Joint pain or stiffness/ swelling		Muscle weakness
Bone fractures		Back pain
Muscle spasms/ cramps		Arthritis
History of injury/ accidents		
Have you ever had a bone density test?		
PERIPHERAL VASCULAR		
Cold hands/ feet		Vein pain (thrombophlebitis)
Varicose veins		Extremity numbness/ swelling/ pain/ ulcers
Deep leg pain/ leg cramps		
NEUROLOGIC		
Fainting		Loss of balance
Seizures/ convulsions		Speech problems/ slurring
Paralysis		Involuntary movement
Numbness or tingling		Loss of memory
ENDOCRINE		
Sensitive to heat or cold		Diabetes
Thyroid problems		Hypoglycemia (low blood sugar)

Excessive thirst/ hunger		Hormone/ steroid therapy	
Excessive urination/ sweating			
BLOOD/ LYMPHATIC			
Anemia		Lymph node swelling	
Easy bleeding/ bruising		Hemophilia	
Blood transfusions		When?	
What is your blood type?			
ALLERGIES			
Any reactions to vaccines?			
Drug sensitivities			
Please list all allergies			
MENTAL EMOTIONAL			
Mood swings		Depression	
Sleeping difficulties/ insomnia		Phobia	
Anxiety		Excess stress	
Have you experienced past trauma/ significant grief?			
Are you still affected by it today?			
Substance abuse		Have you been treated for substance abuse?	
Thoughts of suicides/ attempts			
Have you ever sought help or used medication to deal with personal problems?			
SLEEP			
How many hours do you usually sleep?		How many hours of sleep do you <i>need</i> ?	
Do you awake well rested?		Do you take naps during the day?	
Do you fall asleep during the day?		Do you talk/ walk in your sleep?	
Grind teeth while sleeping		Have vivid dreams	
Sleep apnea		Shift work	
Do you take medication or other substances to help you sleep?			
ENERGY			
How is your energy? (please choose one)			
a) I have plenty of energy for work and for all my daily activities			
b) I have enough energy during work, but feel tired for the rest of the day			
c) I don't have enough energy for work or any other activities			
What affects your energy level?			
EXERCISE			
How would you describe your daily activity level?			
a) very active			
b) moderately active			
c) sedentary			
Do you exercise regularly?		How frequently?	
What kind?		How long?	

FAMILY MEDICAL HISTORY			
Has anyone in your family (siblings, parents, grandparents) had the following conditions?		Which member was affected by this condition	Age
Heart disease			
High blood pressure			
Diabetes/ blood sugar problems			
Asthma			
Allergies			
Cancer (breast, colon, lung, liver, skin, prostate etc)			
Psychiatric (depression, anxiety, addiction etc)			
Kidney problems			
Hormonal problems (thyroid, pituitary, estrogen, testosterone, adrenal (cortisol) etc)			
Congenital (birth)/ developmental problem			
Neurologic problems (eg. MS, parkinson's, Alzheimer's)			
Arthritis			
Other			

Additional comments:

Thank you for investing time and energy in your health. I look forward to working with you on this journey to better health and wellness, Dr Marlene Senaratne, BSc(Hon), ND.