Review of Systems Patient Name_____ File #_____

Instructions: Circle the appropriate conditions If no conditions apply circle No Significant Symptoms.

Constitutional Symptoms: No Significant Symptoms – physical weakness or lack of energy – Chills – Fatigue – Daytime Drowsiness – Fever – Heat intolerance - Cold Intolerance – Hx of Chronic Fatigue – Malaise – Muscle aches – Night sweats – Weight gain – Weight loss - _____

Eyes: No Significant Symptoms – Blindness – Blurred Vision – Cataracts – Color Blindness – Contacts – Double Vision – Glasses – Glaucoma – Blindness in half the field of your vision – Inflammation – Irritation (discharge/redness) – Itchy – Macular Degeneration – Pain – Excessive Tearing - Trauma – Change in Vision – Visual disturbance – Visual loss – Watery eyes - _____

Ears, Nose, Mouth and Throat: No Significant Symptoms – Family History of Cancer –

Ears: Deafness Acquired – Deafness Congenital – Discharge – Ear Aches – Dizziness – Feeling like you are spinning in a circle – Headaches – Hearing Loss – Frequent Infections – Mastoiditis – Operations – Pain – Ringing in the ears – Vertigo - _____

Nose: Congestion – Snoring – Frequent Runny Nose – Discharge – Loss of Smell – Frequent nose bleeds – Obstructions polyps/deviated septum from trauma - Chronic Stuffy Congested – Sinus Infections – Sinusitis - _____

Mouth: Bleeding Gums – Dental Caries – Dentures – Dental Infections – Discolored Gums – Dry Mouth – Gum Disease – Lesions in the Mouth - Loss of Taste – Snoring – Mouth Pain or Soreness - Tongue Pain or Soreness – Tooth Pain - _____

Throat: Laryngitis – Hoarseness – Lump in Throat Sensation – Sore Throat – Tonsillitis – Changes in Voice - _____

Chest/Breast: No Significant Symptoms – History of Breast Cancer – History of Breast Cancer in the Family – Fibrocystic Breast disease – Benign Biopsy – Developmental Problems – Discharge - Injury – Mass – Nipple Abnormality – Pain - Swollen Male Breast Tissue – Unequal Size _____

Respiratory System: No Significant Symptoms – Allergen Exposure – Asthma – History of Bronchitis – Cough – Chronic Obstructive Pulmonary Disease (COPD) – Coughing up Blood - Coughing up Saliva and Mucous – Emphysema – Exposure to Irritant – History of Lung Cancer in Family – Lung Infections – Night Sweats – Pain in the Lungs – Pain with Inhaling – History of Pneumonia – Family History of Lung Problems * – Shortness of Breath while Lying Flat on Back – Shortness of Breath with Exertion – Attacks of Severe Shortness of Breath and Coughing while Sleeping – Shortness of Breath while Resting – Smoker or Tobacco use* - Exposed to Tuberculosis – Wheezing - _____

Cardiovascular System (Heart): No Significant Symptoms – History of Heart Disease – Congestive Heart Failure – Heart Attack – Stroke – Valve Replacement – Valve Disease – Excess Abdominal Fluid – Artificial Valve - Bypass Surgery – Coronary Artery Bypass Graft – Defibrillator – Pacemaker – Stent Placement – Abnormal EKG – Angina – Endocarditis – Irregular Heartbeat – Mitral Valve Prolapse – Pericarditis – Rheumatic Fever – Wolf/Parkinson/White Syndrome – Chest Discomfort – Chest Pain* - Cold Hands and Feet – Chronic Cough – Bluish or Grayish Coloration of Skin, Nails, Lips or around the Eyes - High Cholesterol – High Blood Pressure – Low Blood Pressure – Taking Heart Medication – Heart Murmur – Pain in legs after walking a short distance – Palpitations – Inflammation of a vein (Phlebitis) – Rapid Heart Beat – Slow Heart Beat (below 60 bpm) – Shortness of Breath when lying flat on your back – Shortness of Breath at night – Shortness of Breath with Exertion – Shortness of Breath without Exertion – Swollen Feet and Ankles – Use Tobacco - _____

Gastrointestinal (Stomach and Digestion) System: No Significant Symptoms – Abdominal Pain – Use Alcohol – Change in appetite – Change in Bowels – Bloating – Colon Cancer – Constipation – Diarrhea – Difficult or Painful Swallowing – Excessive Belching – Excessive Intestinal Gas – GERD- History of Stomach and Digestive problems in the Family – Personal History of Stomach and Digestive Problems – History of Stomach and Digestive Cancer in the Family – Heartburn – Hemorrhoids – Indigestion – Jaundice (yellowing of the skin) – Liver Disease – Nausea – Rectal Pain – Reflux – Abnormal Stools – Abdominal Surgical History - Stomach Ulcers – General Vomiting – Recent Weight Gain or Loss -

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Genitourinary System: No Significant Symptoms – Birth Control – Bedwetting – Blood in urine – Difficulty Starting Urine Flow – Erectile Dysfunction – Flank Pain – Surgical History – Hx of Exposure to Sexually Transmitted Diseases – Hydrocele(scrotum filled with fluid) – Impotence – Unable to urinate – Unable to empty bladder – Loss of bowel and bladder control – Kidney Stones – Get up at night to urinate – Pain with Urination – Enlarged Prostate – Prostate Cancer – Prostate Surgery – Re-occurring Prostatitis – Abnormal PSA – History of Kidney Stones – Bloody Semen – Testicular Mass – Testicular Pain – Abnormal Urination – History of Urinary tract Infections _____

Musculoskeletal System: No Significant Symptoms – Night Time Cramps – Numbness – Pain – Migratory Pain – Swelling – Tingling – Wear Bearing Difficulties – Arthritis – Back Pain – Claudication – Disabled – Kidney or Urinary Tract Infection – Limitation of movement – Loss of motion – Muscle pain – Muscle Atrophy – Muscle Inflammation – Paralysis – Muscle Weakness - Stiffness – Joint Pain – Joint Swelling – Trauma or recent Injury

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Skeletal System: Abnormal Posture – Arthritis – Artificial Joints – Dislocation – Fractures – Gout – Joint Pain – Joint redness – Joint Swelling – Limitation of Motion – Morning Stiffness –

Osteoarthritis – Psoriatic – Rheumatism – Rheumatoid Arthritis – Neck Surgery – Lower Back Surgery – Sprains _____

Integumentary System (Skin): No Significant Symptoms – Bruising – Color Change – Sweating – Dry Skin – Edema – Hair and Nail Changes – Hair Loss – Hyperpigmented areas – itching – Tendency toward Keloids(scarring) – Latex Allergy – Lesions – Lumps – Melanoma – New or changing Moles – Rash – Skin Cancer – Sores – Staph Infections – Varicose Veins – Warts

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Neurological System: No Significant Symptoms –

Autonomic: Bluish or grayish coloration of skin – Redness of the skin – Loss of bowel or bladder control – Pale Skin – Reaction to heat or cold _____

Cranial Nerves: Difficulty Swallowing – Facial Weakness – Hearing disturbance R/L Bilat – Loss of Balance – Limited Neck Movement – Numbness and Tingling in the Mouth and Face – Smell Disturbance – Problems with Speech, Swallowing and Taste – Visual Disturbance -Lazy Eye – Blurred Vision – Double Vision _____

Head: Blackout/Fainting – Confusion – Dizziness – Headaches – Memory Loss – Trauma to Head Vertigo _____

Motor: Convulsions – Seizures – Incoordination – Involuntary Movements – Mini-Strokes – Motor Skill Loss – Muscular Atrophy – Paralysis – Stroke – Coma – History of Paralysis – Restless Leg Syndrome – Unsteadiness of Gait _____

Sensory: Burning Sensation – reduced sensation on the skin – Numbness – Shooting Pain – Radiating pain – Sensation Loss – Tingling – Weakness _____

Psychiatric System: No Significant Symptoms – Anxiety Problems - Anger Issues – ADD – ADHD – Alcohol Abuse – Bipolar – Behavioral Changes - Brain Trauma or Damage – Chronic Pain – Chronic Fatigue Syndrome – Depression – Depressive Symptoms – Difficulty adapting to change – Dementia – Drug abuse - Lack of Motivation – Loss of Interest – Suicidal Thoughts - Excessive worrying – Fibromyalgia - Drug Abuse – Panic Disorder – Personality Disorder – Schizophrenia – Suicide Attempts or Gestures – Grandiose Ideas – Hallucination – Inability to Handle Daily Functions of Life – Inadequate (poor) Relationships – Loss of appetite - Memory Loss - Mood Changes – Nervousness – Obsessive Compulsive Disorder - Panic Attacks – Psychiatric Disorders in other family members -Personality Changes – Taking anti-depressants, OTC sleep medication, Prescription Sleep Medication, Tranquilizers – Sleep disturbance/Insomnia – Tension - Uncontrolled Mood Swings – Weight Changes

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Endocrine System: No Significant Symptoms – Abnormal Thyroid – Change in Hand and Foot size – Diabetes – Diabetic Symptoms: Blurred Vision – Glucose in the urine – Excessive

Thirst – Excessive Hunger – Frequent Urination – Weight Loss. Excessive sweating – Hair Distribution – Hair Loss – Head Size – Heat or cold intolerance – Impotence – Nutritional Problems – Obesity – Loss of Skin Pigmentation – Darkening of skin Pigmentation – Abnormal Sexual Development - Sterility – Thyroid Disease – Weakness _____

Hematologic and Lymphatic Systems: No Significant Symptoms – Abnormal Thyroid – Anemia – Bruising – Brown or purple spots due to bleeding under the skin(purpura) – Spontaneous Bruising – Traumatic Bruising - Blood Transfusions - Carotid Blockage – Clotting Problems – Hepatitis – Family History of Hemoglobinopathy – HIV – HIV Infection – Enlarged Lymph Nodes – Enlarged Single Lymph Node – Open Draining Lymph Node – Painful Lymph nodes – Suppuration(pus formation) of a Lymph Node – Hodgkin's disease – Acute Lymphocytic Leukemia – Acute Myelogenous Leukemia – Chronic Lymphocytic Leukemia – Non-Hodgkin's Lymphoma _____

Allergic and Immunological Systems: Allergy – Allergy Treatment – Asthma – Conjunctivitis – Use Antihistamines Seasonally or Regularly – Past Desensitization – Present Desensitization - Hay fever – Migraine Headaches – Stuffy Nose(rhinitis)

Skin Diseases: Atopic (hyperallergic)Dermatitis – Eczema/Dermatitis – Angioneurotic Edema – Chronic Urticaria (hives) _____

Kidney Renal System: No Significant Symptoms – Blood in the Urine – Burning sensation with urination – Frequency of urination – Incontinence (loss of control) – Have to get up at night to urinate – Pain with urination – Renal Failure

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Past Health History:

Please fill out carefully as these problems can affect your overall course of care.

Who is your medical doctor? Please include contact information:

_____

Yes / No I have seen other chiropractors, medical physicians or physical therapists for this condition.

If you answered the last question yes please complete the remainder of the page. If you answered no please skip to the next page.

Dr. _____ Location_____ Last Visit_____

Type of treatment:

_____

_____

Was the treatment beneficial in resolving the condition? Yes No

Please explain:

_____

_____

Dr. _____Location_____ Last Visit_____

Type of treatment:

_____

_____

Was the treatment beneficial in resolving the condition? Yes No

Please explain:

_____

_____

If there is additional information please list it on the back.

Do you, or have you ever, smoked/chewed tobacco? Yes No

If yes, please indicate how much and for how long and/or when you quit.

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_____

List any/all medication you are currently taking.

Medication	Dosage	For what condition?	For how long?

List any/all allergies to Medications

_____

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_____

If over 45, when was your last mammogram?_____

If over 65, when was your last flu shot?_____

When was your last pneumonia vaccination? _____

Childhood Illnesses: Please circle those that apply:

ADD	Seizure disorder	Measles	Psoriasis
Chicken Pox	Allergies/Hay fever	Spina Bifida	Cerebral Palsy
Headaches	Depression	Asthma	Food Allergies
Scoliosis	HIV	Ear Infections	Rash
Eczema	Sickle cell anemia	Mumps	Other:
Crohn's/Colitis	Anemia	Bed-wetting	
Hepatitis	Diabetes	Fetal Drug Exposure	

Adult Illnesses: Please circle all that apply:

ADD	Diabetes (non insulin)	Cancer	Thyroid problems
Cystic	Arthritis	Emphysema	Crohn's/Colitis
Kidney Disease	Diabetes (Insulin Dep.)	STD's	Heart Disease
Hypertension	Liver Disease	Cerebral Palsy	Pneumonia
Psychiatric Problems	Seizures	Eye problems	Vertigo
Alzheimer's	Lung Disease	Multiple Sclerosis	RSD
Depression	Shingles	Suicidal	Hepatitis
Influenza pneumonia	Asthma	Chicken Pox	Stroke
Scoliosis	Eczema	Fibromyalgia	HIV
Anemia	Lupus	Parkinson's	Psoriasis

Other:

Surgeries: Please circle the procedures and include a date when it was done:

Angioplasty	Joint Reconstruction	Heart Surgery	Laminectomy
Cosmetic	Rotator Cuff	Gall bladder	Coronary Bypass
Hysterectomy	Caesarian Section	Knee repair	Hernia
Pacemaker insertion	Dental surgery	Tonsillectomy	Mastectomy
Appendectomy	Joint Replacement	Carpel Tunnel	Other:
D & C	Spinal fusion	Hemorrhoidectomy	

Injuries: Please circle all that apply and include a date when it occurred:

Back Injury	Head injury (no loss of consciousness)	Soft tissue injury (moderate)	Joint injury
Head Injury (with loss of consciousness)	Broken Bones	Disability	Fracture Laceration (severe)
Motor Vehicle Accident	Soft tissue Injury (mild)	Industrial accident	Fall
Other:			

Family History: Circle those things that apply: List conditions in the spaces provided.

General family	alive	deceased	normally developed	no significant disease	Has/Had:_____
Father	alive	deceased	normally developed	no significant disease	Has/Had:_____
Mother	alive	deceased	normally developed	no significant disease	Has/Had:_____
Paternal grandfather	alive	deceased	normally developed	no significant disease	Has/Had:_____
Paternal grandmother	alive	deceased	normally developed	no significant disease	Has/Had:_____
Maternal grandfather	alive	deceased	normally developed	no significant disease	Has/Had:_____
Maternal grandmother	alive	deceased	normally developed	no significant disease	Has/Had:_____
Son(s)	alive	deceased	normally developed	no significant disease	Has/Had:_____
Daughter(s)	alive	deceased	normally developed	no significant disease	Has/Had:_____
Brother(s)	alive	deceased	normally developed	no significant disease	Has/Had:_____
Sister(s)	alive	deceased	normally developed	no significant disease	Has/Had:_____

Office Use Only:

Height: _____ Weight: _____ BP: _____ Pulse: _____