REVIEW OF SYSTEMS

Please check ONLY the symptoms you are having RIGHT NOW

	CONSTITUTIONAL
	Night sweats
	Fatigue
	Abnormal Weight loss
	Abnormal Weight gain

	SKIN
	Breast lumps/pain
	Skin disorders
	Rash

	NEUROLOGICAL
	Concentration loss
	Dizziness
	Headache
	Numbness
	Poor Sleep
	Stress

	EYES
	Blurred vision
	Eye pain
	Sensitivity to light
	Wears glasses

	PSYCHIATRIC
	Irritable
	Anxiety
	Bipolar disorder
	Depression
	Confusion
	Suicidal thoughts

	ALLERGIES
	Food allergies
	medications
	Animal dander
	Pollen

	CARDIOVASCULAR
	Swelling of legs
	Chest pain
	Heart murmur
	Heart problems
	High blood pressure
	Low blood pressure
	Palpitations

	GENITOURINARY
	Birth control pills
	Irregular menstruation
	Prostate problems

	BLOOD / LYMPHATIC
	Blood clots
	Lymph node swelling

	RESPIRATORY
	Asthma
	Shortness of breath
	Coughing up blood

	GASTROINTESTINAL
	Abdominal pain
	Constipation
	Diarrhea
	Hemorrhoids
	Hernia
	Nausea
	Vomiting

	ENDOCRINE
	Diabetes
	Excessive thirst

	MUSCULOSKELETAL
	Arthritis
	Neck pain
	Head heaviness
	Low back pain
	Stiffness
	Muscle weakness
	Muscle cramps
	Muscle weakness

	EARS, NOSE, THROAT
	Difficulty swallowing
	Ear pain
	Hearing loss
	Loss of taste
	Loss of smell
	Ringing in the ears

YOUR HISTORY

✔	Past Problem	When and Explain
	Cancer	
	Stroke	
	Thyroid Problems	
	Asthma	
	Heart Attack	
	HIV/AIDS	
	Angina/Chest Pain	
	Diabetes	
	Broken Bones/Fracture	
	Depression	

List all surgeries and year:____

List all Injuries and year:____

List all medications:____

FAMILY HISTORY

Has anyone in your family had any of these diseases? Check those that apply.	Grandmother	Grandfather	Father	Mother	Siblings
Cancer					
Heart Disease					
High blood pressure					
Stroke					
Diabetes					
Back or Neck Problems					

SOCIAL HISTORY

Do you exercise? Regularly Frequently Occasionally Never **At what level?** Competitive High Medium Low

Sufficient Rest? Always Mostly Sometimes Never **Hours of Sleep?**________

Smoking Status: ☐ *Current smoker* Smoking start date:________ Packs/day:_____ ☐ *Never smoker*

☐ *Former smoker* Quit date:________ ☐ In an effort to quit smoking, I am currently taking:________

Do You Drink Alcohol? Yes No Drinks per Day: