

Review of Systems/Health History

Name: _____

Please circle: C= Current condition/circumstance

Date: _____

P= Past condition/circumstance

General:

Fatigue C P
Night sweats C P

Skin:

Rashes C P
Eczema, hives C P
Other: _____ C P

Head:

Headaches C P
Migraines C P
Hair loss C P
Head injury C P
Dizziness C P

Eyes:

Change in vision C P
Double vision C P
Eye pain C P
Tearing/Dryness C P
Glasses/Contacts C P

Ears:

Hard of hearing C P
Ringing C P
Earache C P

Nose/Sinuses:

Frequent colds C P
Stiffness C P
Sinus infections C P
Hay fever C P
Nose bleeds C P

Mouth & throat:

Sore Throat C P
Swollen Tongue C P
Difficulty swallowing C P

Neck:

Lumps C P
Pain or stiffness C P

Respiratory:

Asthma C P
Emphysema C P
Frequent cough C P
Bronchitis C P
Shortness of Breath C P
Wheezing C P
Pain on breathing C P
Pneumonia C P

Cardiovascular:

Heart failure C P
Heart attack C P
Chest pain/angina C P
High blood pressure C P
High cholesterol C P
Fluttering in chest C P
Heart murmur C P
Ankle Swelling C P

Gastrointestinal:

Frequent indigestion C P
Nausea C P
Vomiting C P
Abdominal pain C P
Liver disease C P
Heartburn C P
Ulcers C P
Hemorrhoids C P
Constipation C P
Diarrhea C P
Frequency Bowel movements: _____

Is this a change: Y N

Urinary:

Pain on urination C P
Increased frequency C P
Dribble urine C P
Frequent infections C P
Kidney stones C P

Musculoskeletal:

Joint pain/stiffness C P
Arthritis C P
Broken bones C P
Osteoporosis C P
Muscle spasms C P
Muscle weakness C P
Loss of coordination C P
Sprains/Strains C P
Low Bk pain/Stiffness C P

Peripheral vascular:

Blood clots C P
Anemia C P
Bleeding/bruising C P
Varicose veins C P
Cold hands/feet C P
Raynaud's disease C P
Cancer C P
Type: _____

Neurologic:

Head injury C P
When: _____
Stroke C P
Seizures C P
Fainting C P
Paralysis C P
Numbness/Tingling C P
Memory loss C P
Loss taste or smell C P
Loss of balance C P

Endocrine:

Hyperthyroid C P
Hypothyroid C P
Heat Intolerance C P
Cold Intolerance C P
Diabetes C P
Excessive Thirst C P

Emotional:

Depression/sadness C P
Anxiety C P
Mood swings C P
Anorexia C P
Bulimia C P

Male reproductive:

Hernias C P
Prostate disease C P
Sexually active C P
Sexually difficulties C P
Difficulty conceiving C P
STD's C P

Female reproductive:

Length of cycles _____
Regular cycles C P
Skipped cycle(s) C P
Breakthrough bleeding C P
Menopausal symptoms C P
Sexually active C P
Pain with intercourse C P
Birth control C P
What type? _____
Difficulty conceiving C P
STD's C P
Sexual difficulties C P
Vaginal infections C P
No. of pregnancies _____
No. of live births _____
No. of miscarriages _____
No. of terminations _____

Name:

Date:

DIET:	Y	N	SLEEP:	Y	N
Do you eat three meals daily			Do you fall asleep easily		
Dietary preferences/sensitivities			Awaken rested		
How many glasses of water do you drink daily ____			Do you typically get 6/8 hrs sleep per night		
Do you drink caffeinated products Types drunk:					
HABITS:	Y	N	EXERCISE:	Y	N
Use Tobacco: <input type="checkbox"/> Now <input type="checkbox"/> Past <input type="checkbox"/> Smoke <input type="checkbox"/> Chew If Past, when did you quit: _____(year) If current: How much: _____ How often: _____			Exercise Routinely What Forms: _____ How Frequently: _____		
Drink Alcohol: <input type="checkbox"/> Now <input type="checkbox"/> Past <input type="checkbox"/> Wine/Beer <input type="checkbox"/> Spirits If Past, when did you quit: _____(year) If consuming: How much: _____ How often: _____			WORK: What Type: _____ Do you wk unusual hrs:	Y	N
Use Recreational Drugs: <input type="checkbox"/> Now <input type="checkbox"/> Past If Past, when did you quit: _____(year) If using: How much: _____ How Often: _____ Type: _____	Y	N	PSYCHOLOGICAL/TRAUMA: Have you ever been abused <input type="checkbox"/> Sexually <input type="checkbox"/> Physically <input type="checkbox"/> Verbally <input type="checkbox"/> Other <input type="checkbox"/> Now <input type="checkbox"/> Past <input type="checkbox"/> Reported <input type="checkbox"/> Resolved	Y	N
SOCIAL: Currently in relationship Healthy/loving/nurturing/safe	Y	N	MENTAL HEALTH: Any current issues Depression/Anxiety	Y	N

CURRENT STRESSORS: _____
HOW DO YOU MANAGE STRESS: _____
HOBBIES: _____

Family Health History: *Immediate blood relatives, i.e. (Grandparents, parents, siblings, aunts/uncles)*

✓	ILLNESS	WHO	Alive or Deceased	✓	ILLNESS	WHO	Alive or Deceased
	Cancer (type)		<input type="checkbox"/> A <input type="checkbox"/> D		Asthma/Respiratory Issues		<input type="checkbox"/> A <input type="checkbox"/> D
	Diabetes I or II		<input type="checkbox"/> A <input type="checkbox"/> D		Alcohol/Drug Abuse		<input type="checkbox"/> A <input type="checkbox"/> D
	Heart Disease Issues Type:		<input type="checkbox"/> A <input type="checkbox"/> D		Liver Disease		<input type="checkbox"/> A <input type="checkbox"/> D
	High/Low Blood Pressure		<input type="checkbox"/> A <input type="checkbox"/> D		Kidney Disease		<input type="checkbox"/> A <input type="checkbox"/> D
	High Cholesterol		<input type="checkbox"/> A <input type="checkbox"/> D		Thyroid Disease		<input type="checkbox"/> A <input type="checkbox"/> D
	Stroke/TIA		<input type="checkbox"/> A <input type="checkbox"/> D		Osteoporosis		<input type="checkbox"/> A <input type="checkbox"/> D
	Anxiety/Depression		<input type="checkbox"/> A <input type="checkbox"/> D		Rheumatoid Arthritis		<input type="checkbox"/> A <input type="checkbox"/> D
	Mental Illness Type:		<input type="checkbox"/> A <input type="checkbox"/> D		Tuberculosis		<input type="checkbox"/> A <input type="checkbox"/> D
	Infectious Diseases/Type		<input type="checkbox"/> A <input type="checkbox"/> D		Autoimmune Disorders Type: Other		<input type="checkbox"/> A <input type="checkbox"/> D

Father: Alive/Deceased (If deceased) **Age:** _____ **Cause of Death:** _____
Mother: Alive/Deceased (If deceased) **Age:** _____ **Cause of Death:** _____

Trauma/Accident History:

Motor Vehicle Accidents: Y N When/Years: _____
Concussions or Loss of Consciousness: Y N Age(s): _____
Broken Bones: Y N Age(s): _____ Significant Falls: Y N Ages: _____
Other traumatic events that may have impacted your health: _____

HOSPITALIZATIONS OR SURGERIES: *Please list reason/type of surgery and date.*

STUDY	DATE	BODY PART	RESULT

Name:

Date:

CURRENT HEALTH CONCERNS:

Adult Health History Form

Reason for Today's Visit: _____

When did your symptoms start: _____

How did symptoms start: _____

Type of Pain: (Please circle all that apply) Burning, Stabbing, Aching, Throbbing, Acute, Chronic, Intolerable, Constant or Sporadic

Severity of Pain: (Please circle) No Pain ≤ 0 1 2 3 4 5 6 7 8 9 10 ≥ Unbearable Pain

What aggravates your pain: _____

What relieves your pain: _____

When is the pain the worst: _____

When is the pain better: _____

Does pain affect your sleep: Y N Please explain: _____

Does pain affect activity or exercise: Y N Please explain: _____

Does pain affect your emotions: Y N Please explain: _____

What diagnostic imaging have you had: Please List : X-RAY, MRI, CT SCAN, OR OTHER

STUDY	DATE	BODY PART	RESULT

Other Treatments and/or types of Practitioners that you've tried: _____

Did it/they help: Y N (if yes, how): _____

CURRENT PRESCRIPTION DRUGS: Please list Drug & Dose or None

SUPPLEMENTS or None

Allergies to Medications (do any of these occur : hives, rash, breathing problems, other):

Allergies to Food, Environmental or Other Substances:

Current Medical Diagnoses 1. _____

None 2. _____

3. _____

4. _____