Berglund Chiropractic & Wellness, LLC - 66 Glenbrook Road, Ste 100, Stamford, CT 06902

Patient Name: _____

Review of Systems

Pulmonary (lung-related): Have you had any of the following issues?
□ Asthma/difficulty breathing □ COPD □ Emphysema □ Other _____ □ **None of the above**

Cardiovascular (heart-related): Have you had any of the following issues or procedures?
□ Heart surgeries □ Congestive heart failure □ Murmurs or valvular disease □ Heart attacks/MIs □ Heart disease/problems □ Hypertension □ Pacemaker □ Angina/chest pain □ Irregular heartbeat □ Other _____ □ **None of the above**

Neurological (nerve-related): Have you had any of the following issues?
□ Visual changes/loss of vision □ One-sided weakness of face or body □ History of seizures □ One-sided decreased feeling in the face or body □ Headaches □ Memory loss □ Tremors □ Vertigo □ Loss of sense of smell
□ Strokes/TIAs □ Other _____ □ **None of the above**

Endocrine (glandular/hormonal): Have you had any of the following related issues or procedures?
□ Thyroid disease □ Hormone replacement therapy □ Diabetes □ Other _____ □ **None of the above**

Renal (kidney-related): Have you had any of the following issues or procedures?
□ Renal calculi/stones □ Hematuria (blood in the urine) □ Incontinence (can't control) □ Bladder Infections
□ Difficulty urinating □ Kidney disease □ Dialysis □ Other _____ □ **None of the above**

Gastroenterological (stomach-related): Have you had any of the following issues?
□ Nausea □ Difficulty swallowing □ Ulcerative disease □ Frequent abdominal pain □ Hiatal hernia □ Constipation
□ Pancreatic disease □ Irritable bowel/colitis □ Hepatitis or liver disease □ Bloody or black tarry stools
□ Vomiting blood □ Bowel incontinence □ Gastroesophageal reflux/heartburn □ Other _____ □ **None of the above**

Hematological (blood-related): Have you had any of the following issues?
□ Anemia □ Regular anti-inflammatory use (Motrin/Ibuprofen/Naproxen/Naprosyn/Aleve) □ HIV positive
□ Abnormal bleeding/bruising □ Sickle-cell anemia □ Enlarged lymph nodes □ Hemophilia
□ Hypercoagulation or deep venous thrombosis/history of blood clots □ Anticoagulant therapy □ Regular aspirin use
□ Other _____ □ **None of the above**

Dermatological (skin-related): Have you had any of the following issues?
□ Significant burns □ Significant rashes □ Skin grafts □ Psoriatic disorders □ Other _____ □ **None of the above**

Musculoskeletal (bone/muscle-related) Have you had any of the following issues?
□ Rheumatoid arthritis □ Gout □ Osteoarthritis □ Broken bones □ Spinal fracture □ Spinal surgery □ Joint surgery
□ Arthritis (unknown type) □ Scoliosis □ Metal implants □ Other _____ □ **None of the above**

Psychological: Have you had any of the following issues?
□ Psychiatric diagnosis □ Depression □ Suicidal ideations □ Bipolar disorder □ Homicidal ideations □ Schizophrenia
□ Psychiatric hospitalizations □ Other _____ □ **None of the above**

Please note anything else from your past medical history that you feel is important to your care here: _____

_____

_____

I have read and understood the above information thoroughly and certify my answers to be correct to the best of my knowledge.

Patient or Guardian Signature _____ **Date**_____