

BOREALIS BEHAVIORAL HEALTH, LLC

Review of Systems/Medical History Update

Patient Name _____ Date of Birth _____

Are you CURRENTLY experiencing any of the following:

General

Good general health lately
Recent weight change
Fever
Fatigue

Yes	No
Yes	No
Yes	No
Yes	No

Eyes and Vision

Eye disease or injury
Blurred or double vision
Glaucoma

Yes	No
Yes	No
Yes	No

Ears, Nose, Throat and Mouth

Hearing Loss
Ringing in the ears
Earaches
Sinus Problems
Dental or chewing problems.
Dentures

Yes	No
Yes	No
Yes	No
Yes	No
Yes	No
Yes	No

Heart trouble

Heart trouble
Chest Pains
Sudden heartbeat changes
Swelling of feet, ankles, hands

Yes	No
Yes	No
Yes	No
Yes	No

Breathing Trouble

Frequent coughing
Spitting up blood
Shortness of breath
Asthma or wheezing

Yes	No
Yes	No
Yes	No
Yes	No

Stomach Trouble

Loss of appetite
Change in bowel movements
Nausea or vomiting
Stomach pain
Gastric Bypass or Lap band

Yes	No
Yes	No
Yes	No
Yes	No
Yes	No

Women:

Any menstrual problems?
Birth control method? _____
Number of Pregnancies _____

Yes	No
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Neurological

Frequent or recurrent headaches
Lightheaded or dizzy
Convulsions or seizures
Numbness or tingling sensations
Tremors or shaking
Involuntary movements
Stroke
Head injury
Balance problems

Yes	No
Yes	No
Yes	No
Yes	No
Yes	No
Yes	No
Yes	No
Yes	No
Yes	No

Hormones

Thyroid disease
Diabetes
Heat or cold intolerance
Change in hair or nails.

Yes	No
Yes	No
Yes	No
Yes	No

Bleeding

Easily bruising or bleeding
Anemia

Yes	No
Yes	No

Urinary

Frequent urination
Burning or painful urination
Blood in urine

Yes	No
Yes	No
Yes	No

Men:

Hormone Irregularities?

Yes	No
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Patient/ Guardian Signature

Date

Reviewed by

Date