Review of Systems

Patient Name: _____ Today's Date:_____ /_____/_____

INSTRUCTIONS: Type **X** if you have it NOW. Type **O** if you have had it in the past but do Not have it now. If **NONE** of the conditions apply to you in an area select **"None." Please take your time and answer completely!**

Constitutional:
__**None**
__Alcohol or Drug Abuse
__Arthritis OA | RA
__Artificial Bones or Joints
__Blood Pressure: High | Low
__Cancer of _____
__Chemotherapy
__Chills
__Chicken Pox
__Do you feel well: □Yes □No
__Daytime drowsiness
__Fatigue
__Fever (Recent or Chronic)
__Fracture of _____
__Guillain-Barre Syndrome
__Hepatitis
__HIV+ / AIDS
__Lyme Disease
__Mumps / Measles
__Night Sweats
__Osteoporosis | Osteopenia
__Polio or Post Polio
__Recent or chronic Infection
__Recent Changes to Bowel
__Rheumatic or Yellow Fever
__Scarlet Fever /Typhoid
__Shingles
__Weight Loss past 6 months
__Venereal Disease

Teeth and Dental:
__**None**
__Amalgams. How many?__
__Dentures or implants
__Extractions
__Root Canals or Crowns

Eyes/Vision:
__**None**
__Blindness
__Blurred Vision
__Cataracts/Cataract Surg
__Change in Vision
__Double Vision
__Eye Pain
__Eye Movement Disorders
__Glaucoma
__Wears Glasses/Contacts

Ears, Nose and Throat:
__**None**
__Chronic Cough
__Dental Implants | Dentures
__Difficulty Swallowing
__Dizziness | Vertigo
__Ear Drainage
__Ear Infection*(s)*
__Ear Pain
__Headaches (Sinus) (Other)
__Head Injury- Current | Past
__Hearing Loss
__Hoarseness
__Loss of Smell
__Nasal Congestion
__Nose bleeds *(frequent)*
__Post Nasal Drip
__Rhinorrhea *(runny nose)*
__Sinus Infections
__Snoring
__Sore Throats
__Tinnitus *-ringing in the ears*
__TMJ Disorder

Respiration:
__**None**
__Asthma
__Blood Production
__Bronchitis
__COPD
__Difficulty Breathing
__Emphysema
__Shortness of Breath
__Sleep Apnea
__Tuberculosis
__Use C-Pap or B-Pap
__Wheezing

Cardiovascular:
__**None**
__Angina *(chest pain)*
__Artificial Valves
__Carotid Artery Blockage
__Carotid Artery Ultrasound
__Chest Pain Other causes
__Claudication *(leg pain)*
__Congenital Heart Defect
__Congestive Heart Failure
__Deep Vein Thrombosis
__Heart Attack | Stroke | TIA
__Heart Murmur
__Heart Disease or Problems
__Heart Stint/bypass Surgery
__Orthopnea *(difficulty breathing while lying down)*
__Mitral Valve Prolapse
__Pacemaker | Defibrillator
__Palpitations *(irregular or rapid heart beat)*
__Rheumatic Fever
__Shortness of Breath
__Swelling of Leg*(s)*
__Ulcers
__Varicose Veins

Gastrointestinal:
__**None**
__Abdominal Pain
__Belching
__Black, Tarry Stools
__Constipation or Diarrhea
__Colitis or Celiac Disease
__Heartburn
__Hemorrhoids
__Indigestion
__Jaundice *(yellowing skin)*
__Nausea
__Rectal Bleeding
__Abnormal Stool Caliber
__Abnormal Stool Color
__Abnormal Stool Size
__Ulcers
__Vomiting

Female:
__**None**
__Birth Control _____
__Breast Lumps / Pain
__Burning Urination
__Frequent Urination
__Hormone Issues/Therapy
__Irregular Menstruation
__PCOS
__Urine Retention
__Vaginal Bleeding
__Vaginal Discharge

Skin:
__**None**
__Changes in Nail Texture
__Changes in Skin Color
__Hair Growth
__Hair Loss
__History of Skin Disorders
__Itching | Rash | Hive
__Paresthesia (numbness, prickling, or tingling)
__Skin Lesions or Ulcers
__Varicosities

Nervous System:
__**None**
__Balance Issues
__Epilepsy
__Fainting | Syncope
__Facial Weakness
__Headaches or Migraines
__Limb Weakness
__Loss of Consciousness
__Loss of Memory
__Numbness of _____
__Seizures
__Sleep Disturbance
__Slurred Speech
__Stress
__Tremors
__Unsteadiness of Gait
__Urine Retention

Psychological:
__**None**
__Anxiety
__Appetite Changes
__Attempted Suicide
__Behavioral Change*(s)*
__Bipolar Disorder
__Confusion
__Convulsions
__Depression
__Hospitalized for evaluation
__Insomnia
__Memory Loss
__Mood Change*(s)*
__Psychiatric Problems
__PTSD
__Sadness | Tearfulness

Allergy:
__**None**
__Anaphylaxis *(history of)*
__Food allergies
__Itching
__Nasal Congestion
__Seasonal allergies
__Sneezing

Hematology:
__**None**
__Anemia
__Bleeding or bleed easy
__Blood Clotting Issues
__Blood Disease(s)
__Blood Transfusion(s)
__Bruises Easily
__Lymph Node Swelling

Male:
__**None**
__Burning/Frequent Urination
__Erectile Dysfunction
__Hesitancy or Dribbling
__Hormone Issues
__Prostate Problems
__Urine Retention

Endocrine:
__**None**
__Cold/ Heat Intolerance
__Diabetes Type I or II
__Excessive Appetite
__Excessive Hunger
__Excessive Thirst
__Frequent Urination
__Goiter
__Hair Loss
__Renal or Kidney problems
__Thyroid Disorders
__Unusual Hair Growth
__Voice Changes

Other not listed:
_____
_____

I agree that it is my responsibility to keep this information up to date. I will report any changes in my conditions, diagnosis, or symptoms to the Doctor. Further, I will report any Doctor visits with my primary care physician or specialist physicians. I understand that the providers (Doctors) I am seeing shall NOT act as or be my primary care physician. This practice is limited to functional medicine. I further assume full responsibility for seeking other doctors as needed for treatments of my conditions, diagnosis, or symptoms.

Patient Signature _____ Doctor Signature: _____