Comprehensive Body Systems Review

For your safety, I must be aware of all medical conditions for which you have been diagnosed or experienced:

Circle all conditions that apply.

Mental & Emotional

Migraines/Headaches, Poor Memory/Concentration/Recall, High Stress, Overwhelmed Easily, Fatigue, Depression, Mood swings, Excess Worry, Anxiety, Suicidal thoughts, Anorexia/Bulimia
Other? Please describe:

Nervous System

Dizziness, Tremors, Nervousness Tingling/Pins & Needles, Numbness, Shooting Pains, Restless Legs, Unsteady Gait, Low/Erratic Energy Levels
Other? Please describe:

Circulatory System

Anemia, Angina, Atherosclerosis, Hemophilia, Congestive Heart Failure, Heart Disease, Heart Attack, Heart Murmur, Stroke, High/Low Blood pressure, High/Low Cholesterol, Varicose or Spider Veins, Swelling, Bruising, Blot Clots, Thrombosis (DVT)
Other? Please describe:

Respiratory System

Breath Irregularities – Short/Shallow, Cough, Asthma, Mucus, Infections
Other? Please describe:

Gastrointestinal (G.I.T) System

Bloating, Flatulence, Heartburn, Indigestion, Pain, Distension, Excess/Loss of Appetite, Fullness after meals, Constipation, Diarrhea, Intolerance of Fatty Foods, Mucus/Blood/Pale/ Black Stools, Anal Itching, Hemorrhoids , Cravings, Bad Breath, Waking between 1-3am, Sluggish Heavy Feeling
Other? Please describe:

Musculoskeletal System

Whiplash, Sore neck and shoulders, Stiffness, Cramps, Sprains, Injuries, Arthritis, Carpal Tunnel Syndrome, Disc or spinal issues, Sciatica, Fibromyalgia, Teeth Grinding, Locked Jaw (TMJ), Repetitive Strain Injuries (RSI)

Other? Please describe:

Endocrine System

Excessive Thirst/Hunger, Fatigue/Exhaustion, Sudden Weight Gain/Loss, Trouble Maintaining/ Losing Weight, Cold Hands & Feet

Other? Please describe:

Urinary System

Past/Present UTI, Frequent Urination, Pain/Blood when Urinating, Incontinence, Loss of Libido, STD/STIs, Lower back pain, Kidney Stones

Other? Please describe:

Immune System

Frequent Colds/Infections, Slow Wound Healing, Cold Sores, Sore Tongue, Swollen Lymph Glands, Food or Environmental Allergies/Intolerance, Hot/Cold conditions, Fevers, Viruses Immune Disorders

Other? Please describe:

Reproductive System

Menstrual Cycle Irregularities, PMS/PMT, High/Low Blood Flow, Hot Flushes, Pain on Intercourse, Tender/Swollen/Painful/Lump in Breasts, OCP, IUD, Cysts, Fibroids, Miscarriage/ Fertility issues, Low/Excess Libido

Other? Please describe:

Sleep

Insomnia, Interrupted Sleep, Difficulty falling asleep, Tired upon Waking, Dream Recall, Nightmares, Night Sweats

Other? Please describe:

Dental Health

Mercury Fillings, Pain, Root Canals, Loss of Teeth, Receding Gums, Gum Sensitivity, Staining/ Yellowing Teeth?

Other? Please describe:

Skin Health

Lesions, Wounds, Rashes, Psoriasis, Eczema, Lumps & Bumps, Excessive Dryness/Itchiness or Hot/Cold conditions?

Other? Please describe:

Serious Illness & Surgeries

Cancer, Tumours, Infectious Diseases, Hospitalization, Past Surgeries

Other? Please describe:

Other

Please add anything that is important that has not been covered above: