Patient Name: ________________________________
Date: _____________ Doctor: _____________

REVIEW OF SYSTEMS

GENERAL

Please mark an "X" on the line next to any of the conditions you have had, and/or you currently have.

1. ___ Eating Disorder	2.___ Diabetes	3.___ Pneumonia	4.___ Multiple Sclerosis
5.___ Epilepsy	6.___ Anemia	7.___ Tuberculosis	8.___ Celiac Disease
9.___ Chronic Pain	10.___ Glaucoma	11.___ Alcoholism	12.___ Heart Disease
13.___ Drug Addiction	14.___ Rheumatic Fever	15.___ Scarlet Fever	16.___ Shingles
17.___ Herpes	18.___ HIV/AIDS	19. Hepatitis, Type ___	20. Rheumatoid Arthritis
21.___ Cancer	22.___ Thyroid Disease	23.___ Hashimoto's Thyroid	

24. Other Autoimmune Disease(s): ____

Doctor's Notes:

Please mark a "P" on the line next to any of the conditions you had PREVIOUSLY, and a "C" on the line next to any of the conditions you have CURRENTLY.

NERVOUS SYSTEM

1.___ Depression	2.___ Anxiety	3.___ Dizziniess	4.___ Memory Difficulty
5.___ Double Vision	6.___ Fainting	7.___ Convulsions	8.___ Weakness/Fatigue
9.___ Poor Balance	10.___ Cold Hands	11.___ Cold Feet	12.___ Twitches/Tremors
13.___ Tingling/Burning	14.___ Face/Eye Pain	15.___ Migraines	16.___ Tension Headache
17.___ Sensory Loss/Numbness		18. Other: _________________________	

EENT

1.___ Vision Correction	2.___ Flashing Lights	3.___ Black Spots	4.___ Blurriness
5.___ Hearing Loss	6.___ Ringing in Ears	7.___ Sinus Pain	8.___ Allergies
9.___ Bleeding Gums	10.___ Loss of Taste	11.___ Loss of Smell	12.___ Difficulty Swallowing
13.___ Thyroid Nodule/Goiter		14. Other: _________________________	

GI

1.___ Poor Appetite	2.___ Excessive Appetite	3.___ Excessive Thirst	4.___ Frequent Nausea
5.___ Constipation	6.___ Diarrhea	7.___ Abdominal Cramps	8.___ Black/Bloody Stools
9.___ Heartburn	10.___ Liver Problems	11.___ Hemorrhoids	12.___ Gall Bladder Problems
13.___ Bowel Movements less than Daily		14. Other: _________________________	

MUSCULOSKELETAL

1.___ Jaw Pain	2.___ Tooth Pain	3.___ Neck Pain	4.___ Difficulty Chewing
5.___ Shoulder Pain	6.___ Arm/Elbow Pain	7.___ Wrist/Hand Pain	8.___ Mid Back Pain
9.___ Lower Back Pain	10.___ Thigh/Knee Pain	11.___ Ankle/Foot Pain	12.___ Difficulty Walking
13.___ Leg or Arm Weakness		14. Other: _________________________	

C-V

1.___ Chest Pain	2.___ Irregular Heartbeat	3.___ High BP	4.___ Shortness of Breath
5.___ Varicose Veins	6.___ Ankle Swelling	7.___ Lung/Congestion Problems	

8. Other: ____

GU

1.___ Bladder Trouble	2.___ Painful Urination	3.___ Incontinence	4.___ Discolored Urine
5.___ Urgency without Volume		6. Other: _________________________	

REPRODUCTIVE

1.___ Erectile Difficulties	2.___ Vaginal Dryness	3.___ Menstrual Irregularity	
4.___ Menstrual Cramping		5. Other: _________________________	

Doctor's Notes:

YOUR GOALS

[*Other than reducing pain*] What abilities or activities have you had difficulty performing because of these problems you are experiencing and would like to return to performing (i.e: playing golf, picking up kids, cleaning the house, etc)? ____
____
____

ADDITIONAL COMMENTS

Please add any additional information you believe the Doctor would find useful in helping you reach your optimal health and wellbeing. ____
____
____

Signature: ____ Date: _________________