SYSTEM REVIEW

PATIENT NAME ________________________________ DATE _____/_____/_____

***PLEASE CHECK ALL FOLLOWING SYMPTOMS THAT YOU HAVE HAD:**

Muscle-Skeletal System

__Low back problems
__Pain btwn shoulders
__Neck problems
__Arm problems
__Leg problems
__Swollen joints

Genital-Urinary System

__Excess urination
__Scantly urination
__Painful urination
__Discolored urine

Female

__Vag. Discharge
__Vag. Bleeding
__Vag. Pain
__Breast Pain
___Lumps on breast
Are you pregnant?
_____yes_____no
Are you nursing?
_____yes_____no
Are you taking birth control?
_____yes_____no

Gastro-Intestinal System

__Poor appetite
__Excess hunger
__Difficult swallowing
__Excess thirst
__Nausea
__Vomiting
__Abdominal pain
__Diarrhea
__Constipation
__Hemorrhoids
__Liver problem
__Gall bladder problem
__Weight problem

Nervous System

__Numbness
__Loss of feeling
__Paralysis
__Dizziness
__Headaches
__Confusion
__Depression

Cardio-Vascular-Respiratory

__Chest pain
__Difficult breathing
__Cough's phlegm
__Cough's blood
__Rapid heartbeat
__Lung problems
__Varicose veins

Eye, Ear, Nose, & Throat

__Eye strain
__Eye inflammation
__Vision problems
__Ear pain
__Ear noises
__Ear discharge
__Hearing loss
__Nose discharge
__Difficult breathing through nose
__Dental problem
__Sore throat
__Hoarseness

Daily Habits

What type of exercise do you perform on a daily basis?_____None_____Moderate____Heavy

What do your daily work habits include? (ex. Sitting, standing, light labor, heavy labor, computer work)

____

What vitamins do you currently take? ____

What kind of other nutritional supplements do you take (if any)? ___________________________________

Do you smoke? ___No _____Yes   How much per day? ____

How much alcohol do you consume on a weekly basis? ____

How much coffee or caffeinated beverages do you consume on a daily basis? ________________________

X____
SIGNATURE OF PATIENT (OR PARENT IF A MINOR)

_________/________/_________
DATE

DATE_____/_____/_______

NAME___________________________DATE OF BIRTH_____/_____/_____SEX________

ADDRESS___________________________CITY____________________ZIP_____________

HOME PHONE_(____)_________________BUSINESS_(___)__________________________

OCCUPATION____

EMPLOYER______________________________________S.S.#________________________

MARITAL STATUS (S) (M) (D) (W) NO. OF CHILDREN____________________

WHO REFERRED YOU TO OUR OFFICE? ____

WHAT IS YOUR PRESENT COMPLAINT? ____

____

____

HOW LONG HAS IT BEEN PRESENT? ____

HAVE YOU SEEN ANOTHER DOCTOR FOR THIS CONDITION? _____________________

IF YES, LIST THE DOCTOR AND THE DIAGNOSIS: ________________________________

____

LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING: ________________________

____

LIST ALL SURGERIES YOU HAVE HAD: ____

____

LIST ALL MAJOR ILLNESSES YOU HAVE HAD: ___________________________________

____

LIST ALL MAJOR ILLNESS IN YOUR FAMILY HISTORY: __________________________

____

LIST ALL ALLERGIES YOU HAVE: ____