Patient Name: Patient Number (office use):_____

Review of Systems

Please check beside any concerns

Had Have

Musculoskeletal
- ○ ○ Neck Problems
- ○ ○ Back Problems
- ○ ○ Joint Problems
- ○ ○ Scoliosis
- ○ ○ Osteoporosis
- ○ ○ Arthritis
- ○ None

Neurological
- ○ ○ Anxiety/Depression
- ○ ○ Weakness
- ○ ○ Headache
- ○ ○ Dizziness
- ○ ○ Numbness/Tingling
- ○ None

Cardiovascular
- ○ ○ High Cholesterol
- ○ ○ High Blood Pressure
- ○ ○ Chest Pain or Angina
- ○ ○ Heart Disease
- ○ ○ Poor Circulation
- ○ None

Respiratory
- ○ ○ Pneumonia
- ○ ○ Asthma
- ○ ○ Seasonal Allergies
- ○ ○ Shortness of Breath
- ○ ○ Emphysema or COPD
- ○ ○ Sleep Apnea
- ○ None

Digestive/GI/GU
- ○ ○ Food Sensitivities
- ○ ○ Kidney Stones
- ○ ○ Incontinence
- ○ ○ Heartburn
- ○ ○ Constipation
- ○ ○ Diarrhea
- ○ ○ Other_____
- ○ None

Women
- ○ ○ Infertility
- ○ ○ PMS
- ○ Currently Pregnant
- ○ Currently Nursing
- ○ Given Birth by C-Section

Men
- ○ ○ Prostate Issues
- ○ ○ Erectile Dysfunction

Constitutional
- ○ ○ Weakness
- ○ ○ Low Energy or Fatigue
- ○ ○ Blood Sugar Issues
- ○ ○ Sudden weight loss/gain
- ○ ○ Poor Appetite

Past Medical History

Illnesses
- ○ Diabetes
- ○ Cancer
- ○ Epilepsy
- ○ Multiple Sclerosis
- ○ Stroke
- ○ Heart Disease
- ○ Shingles
- ○ Other

_____

- ○ None

Operations
- ○ Joint Surgery_____
- ○ Cardiovascular Surgery
- ○ Cancer
- ○ Spinal Surgery
- ○ Other _____
- ○ None

Family History
- ○ Stroke
- ○ Cancer
- ○ Cardiovascular Disease
- ○ Diabetes
- ○ Other _____

Social History

Alcohol Use
- ○ Excessive ○ Social ○ None

Recreational Drug Use
- ○ Yes ○ No

Exercise
- ○ Daily
- ○ Weekly
- ○ Never/Not Much at All

Tobacco Use
- ○ None
- ○ Smoke
- ○ Smokeless

Diet Quality
- ○ Watch very closely
- ○ Limit myself
- ○ My eating is poor

Soft Drinks
- ○ Daily
- ○ Weekly
- ○ Never

Coffee
- ○ Daily
- ○ Weekly
- ○ Never

Stress
- ○ Severe
- ○ Moderate
- ○ Mild

List Any Medication Allergies

_____
_____
_____

List Prescription Medications and Dosages (We can happily make a copy of your list instead of writing here)

_____
_____
_____

List Vitamins and Supplements

_____
_____
_____

Is there anything else we should know?

_____
_____
_____

Doctor's Initials_____