Review of Systems/Health History

Name:

Please circle: C= Current condition/circumstance
P= Past condition/circumstance

Date:

General:
Fatigue C P
Night sweats C P

Skin:
Rashes C P
Eczema, hives C P
Other: _____ C P

Head:
Headaches C P
Migraines C P
Hair loss C P
Head injury C P
Dizziness C P

Eyes:
Change in vision C P
Double vision C P
Eye pain C P
Tearing/Dryness C P
Glasses/Contacts C P

Ears:
Hard of hearing C P
Ringing C P
Earache C P

Nose/Sinuses:
Frequent colds C P
Stuffiness C P
Sinus infections C P
Hay fever C P
Nose bleeds C P

Mouth & throat:
Sore Throat C P
Swollen Tongue C P
Difficulty swallowing C P

Neck:
Lumps C P
Pain or stiffness C P

Respiratory:
Asthma C P
Emphysema C P
Frequent cough C P
Bronchitis C P
Shortness of Breath C P
Wheezing C P
Pain on breathing C P
Pneumonia C P

Cardiovascular:
Heart failure C P
Heart attack C P
Chest pain/angina C P
High blood pressure C P
High cholesterol C P
Fluttering in chest C P
Heart murmur C P
Ankle Swelling C P

Gastrointestinal:
Frequent indigestion C P
Nausea C P
Vomiting C P
Abdominal pain C P
Liver disease C P
Heartburn C P
Ulcers C P
Hemorrhoids C P
Constipation C P
Diarrhea C P
Frequency Bowel movements: _____

Is this a change: Y N

Urinary:
Pain on urination C P
Increased frequency C P
Dribble urine C P
Frequent infections C P
Kidney stones C P

Musculoskeletal:
Joint pain/stiffness C P
Arthritis C P
Broken bones C P
Osteoporosis C P
Muscle spasms C P
Muscle weakness C P
Loss of coordination C P
Sprains/Strains C P
Low Bk pain/Stiffness C P

Peripheral vascular:
Blood clots C P
Anemia C P
Bleeding/bruising C P
Varicose veins C P
Cold hands/feet C P
Raynaud's diseas e C P

Cancer C P
Type:_____

Neurologic:
Head injury C P
When:_____
Stroke C P
Seizures C P
Fainting C P
Paralysis C P
Numbness/Tingling C P
Memory loss C P
Loss taste or smell C P
Loss of balance C P

Endocrine:
Hyperthyroid C P
Hypothyroid C P
Heat Intolerance C P
Cold Intolerance C P
Diabetes C P
Excessive Thirst C P

Emotional:
Depression/sadness C P
Anxiety C P
Mood swings C P
Anorexia C P
Bulemia C P

Male reproductive:
Hernias C P
Prostate disease C P
Sexually active C P
Sexually difficulties C P
Difficulty conceiving C P
STD's C P

Female reproductive:
Length of cycles _____
Regular cycles C P
Skipped cycle(s) C P
Breakthrough bleeding C P
Menopausal symptoms C P
Sexually active C P
Pain with intercourse C P
Birth control C P
What type? _____
Difficulty conceiving C P
STD's C P
Sexual difficulties C P
Vaginal infections C P
No. of pregnancies _____
No. of live births _____
No. of miscarriages _____
No. of terminations _____

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Provider Initials_____

DIET:	Y	N	**SLEEP:**	Y	N
Do you eat three meals daily			Do you fall asleep easily		
Dietary preferences/sensitivities			Awaken rested		
How many glasses of water do you drink daily ____			Do you typically get 6/8 hrs sleep per night		
Do you drink caffeinated products Types drunk:					
HABITS:	Y	N	**EXERCISE:**	Y	N
Use Tobacco: ☐Now ☐Past ☐Smoke ☐Chew If Past, when did you quit:_____(year) If current: How much:_____How often: _____			Exercise Routinely What Forms:_____ How Frequently: _____		
Drink Alcohol:☐Now ☐Past ☐Wine/Beer ☐Spirits If Past, when did you quit:_____(year) If consuming: How much:_____How often: _____			**WORK:** What Type: _____ Do you wk unusual hrs:	Y	N
Use Recreational Drugs: ☐Now ☐Past If Past, when did you quit:_____(year) If using: How much:_____How Often: _____ Type: _____	Y	N	**PSYCHOLOGICAL/TRAUMA:** Have you ever been abused ☐Sexually ☐Physically ☐Verbally ☐Other ☐Now ☐Past ☐Reported ☐Resolved	Y	N
SOCIAL: Currently in relationship Healthy/loving/nurturing/safe	Y	N	**MENTAL HEALTH:** Any current issues Depression/Anxiety	Y	N

CURRENT STRESSORS: _____
HOW DO YOU MANAGE STRESS: _____
HOBBIES: _____

Family Health History: *Immediate blood relatives, i.e. (Grandparents, parents, siblings, aunts/uncles)*

✓	ILLNESS	WHO	Alive or Deceased	✓	ILLNESS	WHO	Alive or Deceased
	Cancer (type)		☐A☐D		Asthma/Respiratory Issues		☐A☐D
	Diabetes I or II		☐A☐D		Alcohol/Drug Abuse		☐A☐D
	Heart Disease Issues Type:		☐A☐D		Liver Disease		☐A☐D
					Kidney Disease		☐A☐D
	High/Low Blood Pressure		☐A☐D		Thyroid Disease		☐A☐D
	High Cholesterol		☐A☐D		Osteoporosis		☐A☐D
	Stroke/TIA		☐A☐D		Rheumatoid Arthritis		☐A☐D
	Anxiety/Depression		☐A☐D		Tuberculosis		☐A☐D
	Mental Illness Type:		☐A☐D		Autoimmune Disorders Type:		☐A☐D
	Infectious Diseases/Type		☐A☐D		Other		☐A☐D

Father: Alive/Deceased (If deceased) **Age:**_____**Cause of Death:** _____
Mother: Alive/Deceased (If deceased) **Age:**_____**Casue of Death:** _____

Trauma/Accident History:
Motor Vehicle Accidents: ☐Y ☐ N When/Years: _____ _____ _____
Concussions or Loss of Consciousness: ☐Y ☐N Age(s): _____ _____ _____
Broken Bones: ☐Y ☐N Age(s):_____Significant Falls: ☐Y ☐N Ages: _____ _____ _____
Other traumatic events that may have impacted your health: _____

HOSPITALIZATIONS OR SURGERIES: *Please list reason/type of surgery and date.*

STUDY	DATE	BODY PART	RESULT

Adult Health History Form

CURRENT HEALTH CONCERNS:

Reason for Today's Visit: _____

When did your symptoms start: _____

How did symptoms start: _____

Type of Pain: *(Please **circle all that apply)** Burning, Stabbing, Aching, Throbbing, Acute, Chronic, Intolerable, Constant or Sporadic*

Severity of Pain: **(***Please circle*) No Pain≤ 0 1 2 3 4 5 6 7 8 9 10 ≥Unbearable Pain

What aggravates your pain: _____ **What relieves your pain:** _____

When is the pain the worst: _____ **When is the pain better:** _____

Does pain affect your sleep: Y N **Please explain:** _____

Does pain affect activity or exercise: Y N **Please explain:** _____

Does pain affect your emotions: Y N **Please explain:** _____

What diagnostic imaging have you had: *Please List : X-RAY, MRI, CT SCAN, OR OTHER*

STUDY	DATE	BODY PART	RESULT

Other Treatments and/or types of Practitioners that you've tried: _____
Did it/they help: ☐**Y** ☐**N** (if yes, how): _____

CURRENT PRESCRIPTION DRUGS: *Please list Drug & Dose or* ☐ **None**

SUPPLEMENTS or ☐ **None**

Allergies to Medications (do any of these occur : hives, rash, breathing problems, other)**:**

_____

Allergies to Food, Environmental or Other Substances:

_____

Current Medical Diagnoses ☐**None**

1. _____
2. _____
3. _____
4. _____