

# 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: \_\_\_\_\_

\_\_\_\_\_