For New Patients- Please review this form and check off any conditions or symptoms that you have experienced in your life.

For Return Patients- Please review this form and check off any ***changes*** in your health since your last visit.

REVIEW OF SYSTEMS

General:
__ Recent weight gain or loss
__ Anorexia/Bulimia
__ Lack of energy
__ Fever/Chills
__ Change in medications
__ Allergies
__ Other _____
__ None

Endocrine/Hormonal:
__ Diabetes
__ Hair loss
__ Thyroid gland problems
__ Excessive hunger/thirst
__ Temperature intolerance-
hot flashes or feeling cold
__ Other_____
__ None

Gastrointestinal:
__ Nausea/Vomiting
__ Hepatitis
__ Diarrhea
__ Blood in stools
__ Constipation
__ Irritable Bowel Syndrome
__ Changing bowel habits
__ Celiac disease/Gluten intolerance
__ Other_____
__ None

Musculoskeletal:
__ Osteoporosis/penia
__ Overall muscle weakness
__ Rheumatoid arthritis
__ Lupus
__ Myasthenia gravis
__ Other_____
__ None

Mental Health Problems:
__ Depression
__ Anxiety disorder
__ Bipolar
__ Other _____
__ None

Head, Eyes, Ears, Nose and Throat
__ Dizziness
__ Loss of sense of smell
__ Headaches
__ Change in vision
__ Ringing in ear
__ Other _____
__ None

Breasts:
__ Discharge
__ Lump
__ Pain
__ Cancer
__ Breast surgery
__Breast Implants
__ Other_____
__ None

Genitourinary:
__ Abnormal menstrual flow
__ Pelvic pain
__ Bladder/kidney infections
__ Vaginal infections
__ Frequent urination
__ Leaking urine
__ Blood in urine
__ Herpes
__ Other_____
__ None

Hematologic:
__ Blood clotting disorder/Blood clots in legs/lungs/etc
__ Sickle cell Anemia
__ Easy bruising
__ Swollen glands/lymph nodes
__ Blood transfusions (dates/reasons_____)
__ Other_____
__ None

Respiratory:
__ Shortness of breath
__ Asthma
__ Bronchitis
__ Pneumonia
__ Bloody cough
__ Other _____
__ None

Neurological Problems:
__ Weakness/Loss of balance
__ Seizures/Epilepsy
__ Headaches/Migraines
__ Numbness
__ Memory loss
__ Other _____
__ None

Skin/Extremities:
__ Unexplained rash/inflammation
__ Acne
__ Skin cancer
__ Moles changing in appearance
__ Excess hair growth
__ Other_____
__ None

Cardiovascular:
__ Elevated Cholesterol
__ Palpitations/Skipped beats
__ Chest pain
__ Heart attack
__ Stroke
__ High blood pressure
__ Rheumatic Fever
__ Valve Disease (Need Antibiotics before dental Procedures? Yes __ No__)
__ Other_____
__ None

Family History (return patients only):
__ Change in health of related person
If yes, please explain_____
_____

On the reverse side, please answer…

1. List all medications, incl supplements
2. What matters to you in regard to your health?
3. What do you want to achieve during today's visit?

Patient Signature_____

Date _____/_____/_____