NATUROPATHIC PERSPECTIVES

Redefining Your Health

Review of Systems

Name: _____ **Date:** _____

Y A condition you have now
N A condition you have NEVER had
P A condition you have had in the past

GENERAL				**Comments**
Weight				
Weight 1 year ago				
Maximum weight				
When				
Height				
Fatigue/Weakness	Y	P	N	

SKIN				**Comments**
Rashes	Y	P	N	
Eczema, Hives (circle)	Y	P	N	
Acne, Boils (circle)	Y	P	N	
Itching	Y	P	N	
Color change	Y	P	N	
Lumps	Y	P	N	
Night sweats/Fevers	Y	P	N	
Dryness/Moistness (circle)	Y	P	N	
Nail changes	Y	P	N	
Changes in Mole	Y	P	N	
Skin Cancer	Y	P	N	

HEAD				**Comments**
Headache	Y	P	N	
Head injury	Y	P	N	
Dizziness	Y	P	N	

NECK				**Comments**
Lumps	Y	P	N	
Swollen glands	Y	P	N	
Goiter (enlarged thyroid)	Y	P	N	
Pain or Stiffness (circle)	Y	P	N	

EYES				**Comments**
Impaired vision	Y	P	N	
Glasses/Contacts	Y	P	N	
Eye pain	Y	P	N	
Tearing or Dryness (circle)	Y	P	N	
Double vision/Blurring (circle)	Y	P	N	
Bothered by sun	Y	P	N	
Itching/Redness	Y	P	N	
Discharge	Y	P	N	

NOSE and SINUSES				**Comments**
Frequent colds	Y	P	N	
Nose bleeds	Y	P	N	
Stuffiness	Y	P	N	
Hay fever	Y	P	N	
Sinus problems	Y	P	N	

MOUTH and THROAT				**Comments**
Frequent sore throat	Y	P	N	
Sore tongue/mouth (circle)	Y	P	N	
Gum problems	Y	P	N	
Hoarseness	Y	P	N	
Dental cavities (specify how many)	Y		N	Number:
Loss of taste	Y	P	N	

EARS				**Comments**
Impaired hearing	Y	P	N	
Earache	Y	P	N	
Discharge	Y	P	N	
Infections	Y	P	N	

RESPIRATORY				**Comments**
Cough	Y	P	N	
Sputum (phlegm)	Y	P	N	

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Spitting up blood	Y	P	N	
Wheezing/Asthma	Y	P	N	
Bronchitis/Pneumonia	Y	P	N	
Emphysema	Y	P	N	
Pain on breathing (circle)	Y	P	N	
Shortness of breath	Y	P	N	
Tuberculosis	Y	P	N	
Tuberculin Test	Y	P	N	
Last Chest x-ray				

CARDIOVASCULAR				**Comments**
Heart disease	Y	P	N	
Angina	Y	P	N	
High blood pressure	Y	P	N	
Murmurs	Y	P	N	
Rheumatic fever	Y	P	N	
Chest pain	Y	P	N	
Palpitations, fluttering	Y	P	N	
Cyanosis (blue lips or extremities)	Y	P	N	
Past ECG (specify when)	Y	P	N	
Other heart tests				

GASTROINTESTINAL				**Comments**
Trouble swallowing	Y	P	N	
Heartburn	Y	P	N	
Change in thirst	Y	P	N	
Change in appetite	Y	P	N	
Nausea	Y	P	N	
Vomiting	Y	P	N	
Vomiting blood	Y	P	N	
Belching or passing gas	Y	P	N	
Blood in stool	Y	P	N	
Jaundice (yellow skin)	Y	P	N	
Liver disease	Y	P	N	
Gall Bladder disease	Y	P	N	
Ulcer	Y	P	N	
Bowel movements - How often?				
- Is this a change?	Y		N	
Rectal bleeding	Y	P	N	
Hemorrhoids	Y	P	N	
Black, tarry stool	Y	P	N	
Abdominal pain	Y	P	N	
Hernias	Y	P	N	

URINARY				**Comments**
Pain on urination	Y	P	N	
Increased frequency	Y	P	N	
Frequent infections	Y	P	N	
Kidney stones	Y	P	N	
Blood in urine	Y	P	N	
Urgency/Hesitancy (circle)	Y	P	N	

MALE REPRODUCTIVE				**Comments**
Hernias	Y	P	N	
Testicular masses	Y	P	N	
Testicular pain	Y	P	N	
Are you sexually active?	Y	P	N	
Sexual difficulties	Y	P	N	
Venereal disease	Y	P	N	
Discharge or sores	Y	P	N	
Sexual orientation: Heterosexual / Bisexual / Homosexual (please circle)				

FEMALE REPRODUCTIVE				**Comments**
Last menstrual period				
Age menses began				
Average number of days of flow				
Length of cycle from start of menses to start of next menses				
Bleeding between periods	Y	P	N	
Are cycles regular	Y	P	N	
Painful menses	Y	P	N	
Excessive flow	Y	P	N	
Pain during intercourse	Y	P	N	
PMS	Y	P	N	
Birth control?	Y	P	N	
What type?				
Number of pregnancies				
Number of live births				
Number of miscarriages				
Number of abortions				
Difficulty conceiving	Y	P	N	
Sexual orientation: Heterosexual / Bisexual / Homosexual (please circle)				
Are you sexually active?	Y	P	N	
Sexual difficulties	Y	P	N	
Venereal Disease	Y	P	N	
Vaginal discharge	Y	P	N	
Vaginal itching	Y	P	N	
Last PAP - (date)				

BREASTS				Comments
Do you do self exams?	Y		N	How often?
Lumps	Y	P	N	
Pain or Tenderness (circle)	Y	P	N	
Nipple discharge	Y	P	N	

MUSCULOSKELETAL				Comments
Joint pain or Stiffness (circle)	Y	P	N	
Arthritis	Y	P	N	
Broken bones	Y	P	N	
Muscle spasms or cramps	Y	P	N	
Joint swelling	Y	P	N	
Backache	Y	P	N	

PERIPHERAL VASCULAR				Comments
Deep leg pain	Y	P	N	
Cold hands/feet	Y	P	N	
Varicose veins	Y	P	N	
Leg cramps	Y	P	N	
Extremity numbness	Y	P	N	
Extremity coldness	Y	P	N	
Extremity swelling	Y	P	N	
Extremity ulcers	Y	P	N	

NEUROLOGIC				Comments
Fainting	Y	P	N	
Seizures/Convulsions	Y	P	N	
Paralysis	Y	P	N	
Muscle weakness	Y	P	N	
Numbness or tingling	Y	P	N	
Loss of memory	Y	P	N	
Involuntary movement	Y	P	N	
Loss of balance	Y	P	N	
Speech problems	Y	P	N	

ENDOCRINE				Comments
Heat or cold intolerance (circle)	Y	P	N	
Thyroid trouble	Y	P	N	
Excessive thirst	Y	P	N	
Excessive hunger	Y	P	N	
Excessive urination	Y	P	N	
Excessive sweating	Y	P	N	
Diabetes	Y	P	N	
Hypoglycemia	Y	P	N	
Hormone therapy	Y	P	N	
Which type?				

BLOOD/LYMPHATIC				Comments
Anemia	Y	P	N	
Easy bleeding or bruising	Y	P	N	
Blood transfusions	Y	P	N	
Lymph node swelling	Y	P	N	

ALLERGIC HISTORY				Comments
Drug sensitivity	Y	P	N	
Reaction to vaccine	Y	P	N	
Allergies? Please list				

EMOTIONAL				Comments
Depression	Y	P	N	
Mood swings	Y	P	N	
Anxiety or nervousness	Y	P	N	
Insomnia	Y	P	N	
Tension	Y	P	N	
Phobias	Y	P	N	

HOBBIES/HABITS			Comments
Do you eat three meals daily?	Y	N	
Do you wake rested?	Y	N	
Do you sleep well?	Y	N	
Do you average 6-8 hours of sleep?	Y	N	
Do you enjoy your work?	Y	N	
Do you watch television?	Y	N	
How many hours/day?			
Do you read?	Y	N	
Do you exercise?	Y	N	
What forms?			
How many times/week?			
Do you take vacations?	Y	N	
Do you use recreational drugs?	Y	N	
Have you been treated for drug dependence?	Y	N	
Do you use alcoholic beverages?	Y	N	
Have you been treated for alcoholism?	Y	N	
What are your main interests and hobbies?			