SYSTEMS REVIEW

Name: ______________________________ Date: ______________

Signature: ______________________________

Please indicate whether you have ever sought medical care or have had a medical problem related to each of the following.

Musculoskeletal (Past)

- ☐ Neck Pain
- ☐ Jaw Pain
- ☐ Shoulder Pain
- ☐ Arm Pain
- ☐ Wrist/Hand Pain
- ☐ Mid-back Pain
- ☐ Low-back Pain
- ☐ Hip-thigh Pain
- ☐ Knee-leg Pain
- ☐ Ankle/Foot Pain
- ☐ Joint Stiffness/swelling
- ☐ Fracture ______________
- ☐ Arthritis past/present
- ☐ Other ______________

Gastro-Intestinal

PAST	PRESENT	
☐	☐	Swallowing Difficulty
☐	☐	Heartburn-Indegestion
☐	☐	Excessive Thirst
☐	☐	Constipation-Irregular Bowell
☐	☐	Irritable Bowell
☐	☐	Ulcer
☐	☐	Hernia
☐	☐	Nausea
☐	☐	Obesity
☐	☐	Gastro-Esophageul Reflux
☐	☐	Abdominal Pain
☐	☐	Appetite Loss
☐	☐	Abnormal Weight Gain/Loss
☐	☐	Ulcerative Colitis
☐	☐	Chrohn's Disease
☐	☐	Liver/Gallbladder Problems
☐	☐	Pancreas
☐	☐	Vomiting
☐	☐	Other______________

Cardiovascular - Repiratory

PAST	PRESENT	
☐	☐	High Blood Pressure
☐	☐	High Cholesterol
☐	☐	Heart Attack
☐	☐	Stroke
☐	☐	Angina (Chest Pain)
☐	☐	Heart Valves
☐	☐	Breathing Difficulties
☐	☐	Aortic Aneurysm
☐	☐	Emphysema
☐	☐	Rapid Heart Beat
☐	☐	Slow Heart Beat
☐	☐	Narrowed Coronary Arteries
☐	☐	Cough
☐	☐	Wheezing
☐	☐	Lungs
☐	☐	Other______________

Hormonal

PAST	PRESENT	
☐	☐	Depression
☐	☐	PMS
☐	☐	Irregular Menstration
☐	☐	Profuse Menstrual Flow
☐	☐	Menstrual Cramps
☐	☐	Breast Soreness/Lumps
☐	☐	Endometriosis
☐	☐	Uterus
☐	☐	Ovaries
☐	☐	Prostate
☐	☐	Testicles
☐	☐	Other______________
☐	☐	Mental Illness

Neurologic

PAST	PRESENT	
☐	☐	Headache
☐	☐	Fainting
☐	☐	Visual Problems
☐	☐	Dizziness
☐	☐	Incoordination
☐	☐	Tinnitus (Ear noises)
☐	☐	Seizure
☐	☐	Paralysis
☐	☐	Weakness
☐	☐	Tremor
☐	☐	Vertigo
☐	☐	Brain
☐	☐	Alzheimer's
☐	☐	Parkinson's
☐	☐	Neuropathy
☐	☐	Diabetes I/II

Immune

PAST	PRESENT	
☐	☐	Asthma
☐	☐	Allergies
☐	☐	Lupus
☐	☐	Rheumatoid Arthritis
☐	☐	Cancer______________
☐	☐	Fibromyalgia
☐	☐	Chronic Fatigue
☐	☐	General Fatigue
☐	☐	Chronic Infections
☐	☐	Spleen
☐	☐	Other______________

SYSTEMS REVIEW

Name: ____ Date: ____________________

Please indicate whether you have ever sought medical care or have had a medical problem related to each of the following.

PAST	PRESENT	
☐	☐	Eyes
☐	☐	Ears
☐	☐	Nose
☐	☐	Throat
☐	☐	Sinus
☐	☐	Tonsils

Skin

PAST	PRESENT	
☐	☐	Dermatitis-Psoriasis
☐	☐	Excema-Rash
☐	☐	Acne
☐	☐	Shingles
☐	☐	Slow Wound Healing

Urinary

PAST	PRESENT		PAST	PRESENT	
☐	☐	Bladder Infection	☐	☐	Frequent Urination
☐	☐	Kidney Stones	☐	☐	Kidney Disorder
☐	☐	Candida	☐	☐	Other____________
☐	☐	Prostate Problems			
☐	☐	Bladder Control			
☐	☐	Painful Urination			

FAMILY HEALTH HISTORY

Indicate which primary family members (Grandparent, Father, Mother or Sibling) with any of the following conditions:

G = Grandparent **F** = Father **M** = Mother **S** = Sibling

G F M S		G F M S		G F M S	
☐ ☐ ☐ ☐	Alcoholism	☐ ☐ ☐ ☐	Degernative Joint Disease	☐ ☐ ☐ ☐	Kidney Disease
☐ ☐ ☐ ☐	Allergies	☐ ☐ ☐ ☐	Depression	☐ ☐ ☐ ☐	Lupus
☐ ☐ ☐ ☐	Alzheimer's Disease	☐ ☐ ☐ ☐	Diabetes	☐ ☐ ☐ ☐	Mental Illness
☐ ☐ ☐ ☐	Anemia	☐ ☐ ☐ ☐	Eczema	☐ ☐ ☐ ☐	MS
☐ ☐ ☐ ☐	Arthritis	☐ ☐ ☐ ☐	Epilepsy	☐ ☐ ☐ ☐	Osteoporosis
☐ ☐ ☐ ☐	Asthma	☐ ☐ ☐ ☐	Gastro Reflux (GERD)	☐ ☐ ☐ ☐	Parkinson's Disease
☐ ☐ ☐ ☐	Bleeding Disorders	☐ ☐ ☐ ☐	Headaches	☐ ☐ ☐ ☐	Prostate Cancer
☐ ☐ ☐ ☐	Breast Cancer	☐ ☐ ☐ ☐	Heart Disease	☐ ☐ ☐ ☐	Rheumatoid Arthritis
☐ ☐ ☐ ☐	Cancer	☐ ☐ ☐ ☐	High Cholesterol	☐ ☐ ☐ ☐	Seizures
☐ ☐ ☐ ☐	Cardiovascular Disease	☐ ☐ ☐ ☐	Hypertension	☐ ☐ ☐ ☐	Skin Caner
☐ ☐ ☐ ☐	Cerebrovascular Disease	☐ ☐ ☐ ☐	Hyperthyroidism	☐ ☐ ☐ ☐	Stroke
☐ ☐ ☐ ☐	Crohn's Disease	☐ ☐ ☐ ☐	Hypothyroidism	☐ ☐ ☐ ☐	Ulcerative Colitis

Vaccinations

If ≥ 65 years old,

1. Did you receive the Pneumococcal vaccine yes ________ No ________ Date _______________
2. Did you receive the flu vaccine yes ________ No ________ Date _______________