Patient Review of Body Systems

Name: ______________________________________DOB: _____________ Date: ___________________

Constitutional

___Fevers/Chills/Sweats

___Unexplained weight loss/gain

___Fatigue/weakness

___Excessive thirst or urination

Musculo-Skeletal

___Muscle/Joint Pain

Ears/Nose/Throat

___Difficulty hearing/ringing

___Hay Fever/Allergies

Cardiovascular

___Chest Pain/Discomfort

___Leg Pain w/Exercise

___Palpitations

Other (please specify)

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____

Dental

___Extractions

___Crowns

___Root Canal

___Gum Disease

___Fillings

___Other

Respiratory

___Cough/Wheeze

___Difficulty Breathing

Gastrointestinal

___Heartburn/Reflux

___Nausea/Vomiting/Diarrhea

___Large bowel dysfunction

___Abdominal Pain

Genitourinary

___ Kidney/Bladder

___ Reproductive organs

Skin

___Rash or Mole

Neurological

___Numbness

___Headaches

Organ Dysfunction

___ Liver/Gall Bladder

___ Spleen/Pancreas

Blood/Lymphatic

___Unexplained Lumps

___Easy Bruising

General Medical History: Past and Current medical problems (please include dates)

___Heart Disease: (specify)

___Diabetes

___Asthma/Lung Disease

___Accidents

___Other: (specify)

___High Blood Pressure

___Thyroid Problem

___Chemical Exposure

___Injuries

___High Cholesterol

___Kidney Disease

___Cancer: (specify)

____

Family History: Please indicate the current status of your immediate family members (Mother, Father, Sibling, Grandparent, Aunt, Uncle)

___High Cholesterol

___Heart Disease

___ Genetic Disorders

___Cancer: type ____

___High Blood Pressure

___Stroke

___Asthma/COPD

___Diabetes

___Bleeding or Clotting

___Other

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