

**REVIEW OF SYMPTOMS**

Are you having, or have you had problems with any of the following:

Circle all that apply

If yes, please explain:

**HEAD, EYES, EARS, NOSE & THROAT**

Frequent headaches, head pain, glaucoma, cataracts, ear infections, hard of hearing, sinus infections, post nasal drip, tonsils and adenoids removed, wear dentures or partial dentures

No Yes \_\_\_\_\_

Date of your last eye exam \_\_\_\_\_

Date of your last dental exam \_\_\_\_\_

**CARDIOVASCULAR**

High blood pressure, heart surgery, stroke, chest pain, need to sleep upright to breathe

No Yes \_\_\_\_\_

**RESPIRATORY**

Shortness of breath, cough, difficulty breathing with activity, use regular prednisone, asthma, COPD

No Yes \_\_\_\_\_

**GASTROINTESTINAL**

Heartburn, diarrhea, constipation, ulcer disease, Reflux, vomiting, nausea

No Yes \_\_\_\_\_

**GENITOURINARY**

Kidney stones, burning with urination, blood in urine, loss of urine

No Yes \_\_\_\_\_

If female, do you menstruate regularly?  Yes  No

Do you take hormones?  Yes  No

How many times have you been pregnant?

How many live births?

**MUSCULOSKELETAL**

Joint pain, joints replaced, osteoarthritis, rheumatoid arthritis, fibromyalgia, fractures

No Yes \_\_\_\_\_

Neck, mid back or low back pain

No Yes \_\_\_\_\_

Use prednisone regularly or injectible cortisone

No Yes \_\_\_\_\_

**NEUROLOGIC**

Epilepsy, migraine headaches, weakness, light headedness, fainting, extremity numbness

No Yes \_\_\_\_\_

**INFECTIOUS DISEASE**

TB, hepatitis, HIV, polio

No Yes \_\_\_\_\_

**LYMPHADENOPATHY**

Swollen glands, tender glands, frequent sore throat

No Yes \_\_\_\_\_

**PSYCHIATRIC/EMOTIONAL**

Depression, anxiety, sleep problems

No Yes \_\_\_\_\_

**ENDOCRINE PROBLEMS**

Diabetes, thyroid disease, goiter, adrenal problems

No Yes \_\_\_\_\_

**BLOOD PROBLEMS**

Difficulty stopping bleeding, blood clots, blood thinners

No Yes \_\_\_\_\_

**SKIN PROBLEMS**

Psoriasis, sores that won't heal, skin cancers, nickel allergy

No Yes \_\_\_\_\_

Reviewed by: \_\_\_\_\_ Date: \_\_\_\_\_

Update \_\_\_\_\_ Update \_\_\_\_\_ Update \_\_\_\_\_ Update \_\_\_\_\_ Update \_\_\_\_\_ Update \_\_\_\_\_ Update \_\_\_\_\_

Name: \_\_\_\_\_ Date: \_\_\_\_\_