

**REVIEW OF SYSTEMS**

<b>General Health</b>
What is your present weight?
Is this weight a change?
If so, what changed? (i.e. diet, lack of exercise)
Maximum weight?
When?
What is your height?

<b>Skin, Hair, Nails</b>	Yes	No	Past
Do you have rashes?			
Do you have eczema?			
Do you have hives or boils?			
Do you have acne?			
Do you have psoriasis?			
Do you have itchy skin?			
Have you noticed a colour change?			
Do you experience fever or chills?			
Do you experience excess sweating?			
Do you experience night sweats?			
Do you have excessive skin dryness?			
Do you have excessive skin moistness?			
Do you experience excessive bruising?			
Any recent changes in moles?			
Any history of skin cancer?			
If so, what type and when?			
Have you had any nail changes?			
If so, what kind of changes?			
Any recent hair loss or thinning of the hair?			
Any change in texture of the hair?			
Any excessive hair growth?			
If so, where?			

<b>Head</b>	Yes	No	Past
Have you ever had a head injury?			
If so, when?			
Have you ever had a head injury with loss of consciousness?			
If so, when?			
Do you experience headaches?			
If so, how often?			
Do you experience dizziness or light-headedness?			
Do you experience migraine headaches?			
If so, how often?			

<b>Eyes</b>	Yes	No	Past
Do you have impaired vision?			
If so, in what way?			
Do you wear glasses or contacts?			
Do you experience any eye pain?			
Do you experience floaters?			
Do you experience blurred vision?			
Do you have cataracts?			
Do you have excess tearing			
Do you have excess dryness?			
Do you experience itchiness?			
Are your eyes sensitive to light?			
Do you experience excessive redness?			
Do you have any discharge?			
Do you have glaucoma?			
If so, what kind?			

<b>Ears</b>	Yes	No	Past
Do you have any loss of hearing?			
Do you experience earaches or infections?			
If so, how often?			
Do you experience any discharge?			
Do you have ringing in your ears or tinnitus?			

<b>Nose and Sinuses</b>	Yes	No	Past
Do you experience frequent colds?			
If so, how often?			
Do you experience nasal discharge?			
Do you experience nosebleeds?			
If so, how often?			
Do you experience hayfever or other allergies?			
Do you experience sinus pain?			
Do you experience sinus infections?			
Do you have any loss of smell?			

<b>Mouth and Throat</b>	Yes	No	Past
Do you experience frequent sore throats?			
If so, how often?			
Do you have any gum disease?			
Do your gums bleed excessively?			
Do you have hoarseness or voice changes?			
Do you get canker sores?			
Do you get cold sores?			

Do you have cavities?			
If so, what kind of filling was used?			
Do you have any loss of taste?			

<b>Neck</b>	Yes	No	Past
Do you experience pain or stiffness?			
Do you have swollen glands in your neck?			
Do you have any lumps in your neck?			
Do you have a goiter?			

<b>Breasts</b>	Yes	No	Past
Do you do breast self exams?			
If so, how often?			
Do you experience pain or tenderness?			
Do you have any rashes on the breast?			
Do you have any nipple discharge?			
Do you have cystic or fibrous breasts (fibrocystic breast disease)?			
Do you have any lumps?			
Have you ever had a mammogram or other breast imaging?			
If so, which one(s)?			
If so, when was your last one(s)?			
Have you ever had an abnormal mammogram or breast biopsy?			
Have you ever had breast cancer?			
Have you ever had any breast surgery?			
If so, what kind? (i.e. breast augmentation, mastectomy)			

<b>Respiratory</b>	Yes	No	Past
Do you have a chronic cough?			
Do you have excessive sputum/discharge?			
Do you spit up blood?			
Do you experience any wheezing?			
Do you have asthma?			
Do you have a history of bronchitis?			
If so, how often?			
Do you have a history of pneumonia?			
If so, how often?			
Do you have a history of pleurisy			
Do you have emphysema?			
Do you have difficulty breathing?			
Do you have pain on breathing?			
Do you have shortness of breath?			
Do you have shortness of breath at night or lying down?			
Have you ever had tuberculosis?			

<b>Cardiovascular</b>	Yes	No	Past
Do you experience an irregular or skipped heart beat?			
Do you experience heart palpitations or a fluttering sensation?			
Do you experience chest pain?			
Do you have angina?			
Do you experience shortness of breath at rest?			
Do you experience shortness of breath on exertion?			
Do you need to sleep on more than one pillow at night?			
If so, how many pillows?			
Do you have a history of heart disease?			
Do you have a history of heart attack			
Do you have a history of heart rhythm problems?			
Do you have a history of heart failure?			
Do you have a history of a heart murmur?			
Do you have high blood pressure?			
Do you have swelling in the ankles?			
Do you have a history of stroke?			
Do you have a history of transient ischemic attacks (TIA)?			
Have you had an ECG?			
If so, when?			
Have you had any other heart tests?			

<b>Gastrointestinal</b>	Yes	No	Past
Is there a change in your appetite?			
Is there a change in your thirst?			
Do you have trouble swallowing?			
Do you experience heart burn?			
Do you experience nausea?			
Do you experience vomiting?			
Do you ever vomit blood?			
How many bowel movements do you have per day?			
Is this a change?			
Do you experience diarrhea?			
Do you experience constipation?			
Do you have abdominal bloating?			
Do you have problems with excessive gas? (i.e. belching, passing gas)			
Do you have abdominal pain?			
Do you experience indigestion?			
Do you have blood in your stool, or tar-coloured stools?			
Do you have a history of irritable bowel syndrome?			
Do you have a history of Crohn's disease?			
Do you have a history of ulcerative colitis?			
Do you have a history of celiac disease?			
Do you have a history of ulcers?			
If so, when?			

Do you have a history of diverticulitis?			
Do you have a history of haemorrhoids?			
Do you have a history of rectal bleeding?			
Do you have a history of hernia?			
Do you have a food allergy?			
If so, to what food(s)?			
Have you ever had appendicitis?			
Have you had your appendix removed?			
Do you have a history of jaundice?			
Do you have a history of liver disease?			
Do you have a history of hepatitis?			
If so, which one(s) (i.e. A, B, C)?			
Do you have a history of liver cirrhosis?			
Do you have a history of enlarged liver?			
Do you have a history of fatty liver disease?			
Do you have a history of gall bladder disease?			
Do you have a history of gall stones?			

<b>Urinary</b>	Yes	No	Past
Do you experience pain or burning on urination?			
Do you experience increased frequency of urination?			
Do you experience increased frequency of urination at night?			
Do you have an inability to hold urine (i.e. while coughing, laughing, sneezing) ?			
Do you experience hesitancy in urine flow (i.e. trouble getting started)?			
Do you experience urgency to urinate?			
Do you have blood in your urine?			
Do you have kidney disease?			
Do you have a history of kidney stones?			
Do you have a history of kidney infections?			
Do you have recurrent bladder infections?			

<b>Male Reproductive</b>	Yes	No	Past
Do you have a history of testicular pain?			
Do you have a history of testicular lumps?			
Do you have a history of pain in the penis?			
Do you have a history of discharge from the penis?			
Do you have a history of sores or lesions on the penis or testicles?			
Do you perform self-exams?			
If so, how often?			
Do you have a history of hernias?			
Do you have a history of sexually transmitted infections?			
Do you have any problems attaining an erection?			
Do you have any problems maintaining an erection?			
Do you experience premature ejaculation?			

Do you have any problems with fertility that you are aware of?			
Have you experienced a change in sex drive?			
If so, in what way?			
Have you ever had a digital rectal exam?			
If so, when was your last one?			

<b>Female Reproductive</b>	Yes	No	Past
At what age did your menses begin?			
What is the average number of days your period lasts?			
What is the average number of days between periods (i.e. your cycle length)?			
When was your last menstrual period?			
Do you experience heavy periods?			
Do you experience bleeding between periods?			
Do you experience abnormally heavy flow?			
If so, is this a change?			
Do you experience abnormally light flow?			
If so, is this a change?			
Do you have irregular periods?			
Do you experience pain or cramping with your periods?			
Do you experience premenstrual symptoms (i.e. tender breasts, mood changes)?			
If so, what do you experience?			
If so, do they disappear with the onset of menses?			
Do you experience a premenstrual headache?			
Have you experienced a cessation of your period (amenorrhea), not due to menopause?			
If so, for how long?			
Have you gone through menopause?			
If so, at what age?			
Did you experience menopausal symptoms?			
If so, what were/are they?			
Do you have hot flashes?			
Do you experience night sweats?			
Have you experienced any post-menopausal bleeding?			
Do you have a history of cysts on your ovaries?			
Do you have a history of uterine fibroids?			
Do you have a history of endometriosis?			
Do you have a history of vaginal discharge?			
Do you have a history of vaginal itching?			
Do you have recurrent yeast infections?			
Have you had an internal exam with PAP smear?			
If so, when was your last one?			
Have you had pelvic surgery (i.e. D & C, removal of cysts, hysterectomy)?			
If so, what kind of surgery?			

Are you currently using birth control?			
If so, what type?			
Do you have any problems with fertility that you are aware of?			
How many pregnancies have you had?			
How many live births have you had?			
How many miscarriages have you had?			
How many medical abortions have you had?			
If you have been pregnant:			
Did you have medical problems during pregnancy (i.e. high blood pressure, gestational diabetes)?			
If so, what problems?			
If you have given birth:			
Did you have any problems postpartum (i.e. depression, inability to breast feed, breast infections)?			
If so, what problems?			
Do you have pain with intercourse?			
Do you have a history of sexually transmitted infections?			
Have you experienced a change in sex drive?			
If so, in what way?			
Do you experience difficulty in achieving an orgasm?			
Have you ever had a cancer of your reproductive organs (i.e. cervical, ovarian)			
If so, which one(s)?			

<b>Muskuloskeletal</b>	Yes	No	Past
Do you have arthritis?			
If so, what form?			
Do you have any joint pain or stiffness?			
Do you have any joint deformity?			
Do you have any joint swelling?			
Do you have any restriction of movement in a joint?			
If any of the above, in which joint(s)?			
Do you have back pain?			
If so, where?			
Does the pain radiate?			
Where does it radiate to?			
Do you have a history of disc disease?			
Do you experience muscle pain?			
Do you experience muscle cramps?			
Do you experience muscle weakness?			
Do you have osteopenia or osteoporosis (loss of bone density)?			
Do you have bone spurs?			
Have you experienced any recent bone fractures?			

<b>Peripheral Vascular</b>	Yes	No	Past
Do you experience coldness in your hands and feet?			
Do you experience numbness in your arms and legs?			
Do you experience tingling in your arms and legs?			
Do you experience deep leg pain?			
Do you experience swelling in your legs?			
Do you have a history of varicose veins?			
Do you have a history of blood clots in your legs (deep vein thrombosis)?			
Do you have a history of leg ulcers?			

<b>Blood, Lymphatic, Immune</b>	Yes	No	Past
Do you have a history of anemia?			
Do you experience easy bleeding or bruising?			
Do you experience swollen lymph nodes (i.e. lumps in your neck, armpit, groin)?			
If so, where?			
Have you had a blood transfusion?			
Do you have frequent infections?			
Do you use antibiotics?			
If so, how frequently?			
Do you have frequent fungal infections?			
Do you experience slow wound healing?			
Do you have a history of autoimmune disease (i.e. systemic lupus, rheumatoid arthritis)?			
If so, which one(s)?			

<b>Brain and Neurological</b>	Yes	No	Past
Do you have a history of seizures?			
Do you experience problems with your memory?			
Do you experience problems concentrating?			
Do you experience difficulty making decisions?			
Do you have trouble learning new material?			
Have you experienced slowed, stuttered or slurred speech?			
If so, when?			
Do you have learning disabilities?			
Do you have problems with physical coordination?			
Do you have a history of paralysis?			
Do you have areas of decreased sensation on your body?			
If so, where?			
Do you have one sided weakness or weakness in one limb?			
If so, where?			
Do you experience loss of balance?			
Do you have a history of fainting or blackouts?			

<b>Endocrine</b>	Yes	No	Past
Do you often feel fatigued or sluggish?			
Do you feel lethargic?			
Do you have episodes of too much energy?			
Do you often feel restless?			
Do you feel tense?			
Do you have problems tolerating cold temperatures?			
Do you have problems tolerating hot temperatures?			
Have you noticed a change in skin pigment?			
Have you noticed a change in skin texture?			
Do you have trouble losing weight even when trying?			
Do you have a history of a thyroid condition?			
If so, what condition?			
Do you experience excessive thirst?			
Do you experience excessive hunger?			
Do you experience excessive urination?			
Do you have a history of diabetes?			
Do you have a history of high blood sugar?			
Do you have symptoms of hypoglycaemia/low blood sugar (i.e. anxiety, a gitation, sweating, faint feeling, sleepiness, mental fog, drop of energy)?			
Do you have a history of high cholesterol?			
Do you have a history of high triglycerides?			
Do you have skin tags?			
Have you been on hormone therapy?			
If so, what?			

<b>Emotional, Lifestyle, Spirituality</b>	Yes	No	Past
Do you experience mood swings?			
Do you have a history of depression?			
Do you have a history of anxiety or nervousness?			
Do you experience panic attacks?			
Do you have a particular phobia?			
If so, to what?			
Do you often feel angry or irritable?			
Do you have a psychiatric illness (i.e. depression, bipolar disorder, schizophrenia)?			
If so, which one(s)?			
Do you have a history of an eating disorder?			
If so, which one?			
Were you ever treated for an eating disorder?			
If so, when?			
Do you experience trouble falling asleep?			
Do you experience trouble staying asleep?			
Do you experience trouble waking too early?			
Do you feel not rested after sleep?			



Do you have a high stress occupation?			
Do you find your occupation satisfying?			
Do you currently have occupational problems?			
Do you currently have financial problems?			
Do you currently have relationship problems?			
Do you currently have other significant family problems (i.e. parents, children)?			
Do you take time off work/vacations?			
Do you feel you are able to cope well with the stress in your life?			
Do you drink alcohol?			
If so, how many drinks per day?			
Has anyone ever told you they thought you had a drinking problem?			
Have you ever been treated for alcoholism?			
If so, when?			
Do you use any recreational drugs?			
If so, which ones?			
How often?			
Have you been treated for drug dependence?			
If so, when?			
Do you use a relaxation technique such as meditation, Yoga, etc. for relaxation?			
Do you consider yourself to be a spiritual person?			
Do you pray or meditate?			
Have spiritual issues concerned you recently?			

***Please feel free to add further details to the bottom of this page and on the back***