

# 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	
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				

<b>CARDIOVASCULAR</b>				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				

<b>GASTROINTESTINAL</b>				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	P	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		

<b>URINARY</b>				Comments
Pain on urination	Y	P	N	
Increased frequency	Y	P	N	
Frequency at night	Y	P	N	
Inability to hold urine	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	

<b>MALE REPRODUCTIVE</b>				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 preference: Heterosexual / Bisexual / Homosexual (please circle)				

<b>FEMALE REPRODUCTIVE</b>				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	What type?	
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		
Number of pregnancies					
Number of live births					
Number of miscarriages					
Number of abortions					
Difficulty conceiving	Y	P	N		
Sexual preference: 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)					

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

<b>MUSCULOSKELETAL</b>				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	

<b>PERIPHERAL VASCULAR</b>	<b>Comments</b>			
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	

<b>NEUROLOGIC</b>	<b>Comments</b>			
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	

<b>ENDOCRINE</b>	<b>Comments</b>			
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?				

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

<b>ALLERGIC HISTORY</b>	<b>Comments</b>			
Drug sensitivity	Y	P	N	
Reaction to vaccine	Y	P	N	
Allergies? Please list				

<b>EMOTIONAL</b>	<b>Comments</b>			
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	

<b>HOBBIES/HABITS</b>	<b>Comments</b>			
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?				