Patient Review of Body Systems

Name: _____ 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)
_____
_____

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

Skin
___Rash or Mole

Neurological
___Numbness
___Headaches

Organ Dysfunction
_____
_____

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
___Bleeding or Clotting
___Asthma/COPD
___Cancer: type _____
___High Blood Pressure
___Stroke
___Genetic Disorders
___Other
___Diabetes

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