Patient Name:	Date:	
	HEALTH SYPTOM HISTORY- REVIEW OF SYSTEMS	

Please circle **YES** for current symptoms, **PAST** for symptoms you have had in the past, or **NO** for symptoms you have never had. Identify if more than occasional symptoms have occurred.

GENERAL HEALTH:

kin			
Rashes/Itching	No	Past	Yes
Inflammation	No	Past	Yes
Infection	No	Past	Yes
Growths	No	Past	Yes
Changes in Hair/Nails	No	Past	Yes
lead			
Headache	No	Past	Yes
Head Injury	No	Past	Yes
Dizziness	No	Past	Yes
yes			
Impaired Vision	No	Past	Yes
Eye Pain	No	Past	Yes
Tearing or Dryness	No	Past	Yes
Double Vision	No	Past	Yes
ars			
Impaired Hearing	No	Past	Yes
Ringing	No	Past	Yes
Earache	No	Past	Yes
Itching	No	Past	Yes
ose & Sinuses			
			.,
Frequent Colds	No	Past	
Nose Bleeds	No	Past	
Stuffiness	No	Past	
Allergies	No	Past	Yes
Mouth & Throat			
Frequent Sore Throat	No	Past	Yes
Sore Tongue	No	Past	Yes
Sores in Mouth/on Lips	No	Past	Yes
Gum Problems	No	Past	Yes
Hoarseness	No	Past	

No Past Yes

Dental Problems

Hemorrhoids

Past Yes

No

Pain on Urination Increased Frequency Inability to Hold Urine Bladder Infections Circulation Cold Hands/Feet Varicose Veins Deep Leg Pain No Past No Past Pes No Past Pes Bleedin PMS Cramp Muscle Weakness No Past No Past Pes No Past Pes No Past Pes No Past Pes No No No No Past Pes No No No No Past Pes No No No Past Pes No No Past Pes No	r Tenderness Discharge f Last Menstruation enses Began etween Cycles ur cycles regular? ive Flow ng Between Periods s mal Discharge pausal Symptoms er of Pregnancies	NO N	Pa P
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Thyroid Problems No Past Yes Venere	:ype?		
Thyroid Problems No Past Yes Venere	uring Intercourse	No	Pa
i i Numpe	eal Disease	No	Pa
Heat or Cold Intolerance No Past Yes	er of Abortions (optiona	al)	
Hypoglycemia No Past Yes Male Re	production		
Excessive Thirst No Past Yes	Ity Urinating	No	Pa
LACESSIVE Hullgel NO Fast 165	te Problems	No	Pa
Lasy Weight dain No Fast 165		No	Pa
Diabetes NO Fast 165	ılar Masses	No	Pa
A	ılar Pain	No	Pa
A	u sexually active?	No	Pa
Digith C	•	No	Pa
Joint Fain of Stiffless No Fast 165			. 0
Covered	Difficulties	No	Pa
blokeli bolles No Fast Tes	Difficulties	No	Pa
motional Discha	eal Disease	No	Pa

Optional Question for Both Sexes

Please circle sexual orientation:					
Heterosexual					
Homosexual					
Bisexual					
Other					

Yes Yes Yes Yes

Yes Yes Yes Yes Yes Yes

Yes Yes Yes

Yes Yes

Yes
Yes
Yes
Yes
Yes
Yes
Yes

Yes Yes Yes

Past

Past

Past

Past

Yes

Yes

Yes

Yes

No

No

No

No

Depression

Tension

Mood Swings

Anxiety or Nervousness