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:

Skin

Symptom			
Rashes/Itching	No	Past	Yes
Inflammation	No	Past	Yes
Infection	No	Past	Yes
Growths	No	Past	Yes
Changes in Hair/Nails	No	Past	Yes

Head

Symptom			
Headache	No	Past	Yes
Head Injury	No	Past	Yes
Dizziness	No	Past	Yes

Eyes

Symptom			
Impaired Vision	No	Past	Yes
Eye Pain	No	Past	Yes
Tearing or Dryness	No	Past	Yes
Double Vision	No	Past	Yes

Ears

Symptom			
Impaired Hearing	No	Past	Yes
Ringing	No	Past	Yes
Earache	No	Past	Yes
Itching	No	Past	Yes

Nose & Sinuses

Symptom			
Frequent Colds	No	Past	Yes
Nose Bleeds	No	Past	Yes
Stuffiness	No	Past	Yes
Allergies	No	Past	Yes

Mouth & Throat

Symptom			
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	Yes
Dental Problems	No	Past	Yes

Neck

Symptom			
Swollen Glands	No	Past	Yes
Pain or Stiffness	No	Past	Yes

Blood

Symptom			
Anemia	No	Past	Yes
Easy Bleeding/Bruising	No	Past	Yes

Respiratory

Symptom			
Cough	No	Past	Yes
Spitting up Blood	No	Past	Yes
Wheezing	No	Past	Yes
Difficulty Breathing	No	Past	Yes
Pain with Breathing	No	Past	Yes
Shortness of Breath	No	Past	Yes
Positive TB Test	No	Past	Yes

Heart

Symptom			
Heart Disease	No	Past	Yes
High Blood Pressure	No	Past	Yes
Rheumatic Fever	No	Past	Yes
Chest Pain	No	Past	Yes
Palpitations/Fluttering	No	Past	Yes
Swelling in Ankles	No	Past	Yes

Digestion

Symptom			
Trouble Swallowing	No	Past	Yes
Belching or Gas	No	Past	Yes
Heartburn	No	Past	Yes
Stomach Pain	No	Past	Yes
Change in Thirst	No	Past	Yes
Change in Appetite	No	Past	Yes
Nausea	No	Past	Yes
Vomiting	No	Past	Yes
Bowels Move	Daily	More	Less
Loose Stools	No	Past	Yes
Hard Stools	No	Past	Yes
Blood in Stools	No	Past	Yes
Liver/Gall Bladder Disease	No	Past	Yes
Hemorrhoids	No	Past	Yes

Patient Name: ____ Date: ____________________

GENERAL HEALTH CONTINUED:

Urinary

Pain on Urination	No	Past	Yes
Increased Frequency	No	Past	Yes
Frequency at Night	No	Past	Yes
Inability to Hold Urine	No	Past	Yes
Bladder Infections	No	Past	Yes

Circulation

Cold Hands/Feet	No	Past	Yes
Varicose Veins	No	Past	Yes
Deep Leg Pain	No	Past	Yes

Neurologic

Fatigue	No	Past	Yes
Muscle Weakness	No	Past	Yes
Numbness or Tingling	No	Past	Yes
Fainting	No	Past	Yes
Seizures	No	Past	Yes
Paralysis	No	Past	Yes
Loss of Memory	No	Past	Yes

Endocrine

Thyroid Problems	No	Past	Yes
Heat or Cold Intolerance	No	Past	Yes
Hypoglycemia	No	Past	Yes
Excessive Thirst	No	Past	Yes
Excessive Hunger	No	Past	Yes
Easy Weight Gain	No	Past	Yes
Diabetes	No	Past	Yes

Musculoskeletal

Muscle Spasms or Cramps	No	Past	Yes
Joint Pain or Stiffness	No	Past	Yes
Weakness	No	Past	Yes
Broken Bones	No	Past	Yes

Emotional

Depression	No	Past	Yes
Mood Swings	No	Past	Yes
Anxiety or Nervousness	No	Past	Yes
Tension	No	Past	Yes

REPRODUCTIVE HEALTH:

Female Reproduction

Breasts- Regular Self-Exams?	No	Past	Yes
Lumps	No	Past	Yes
Pain or Tenderness	No	Past	Yes
Nipple Discharge	No	Past	Yes
Date of Last Menstruation	______________		
Age Menses Began	______________		
Days between Cycles	______________		
Are your cycles regular?	No	Past	Yes
Excessive Flow	No	Past	Yes
Bleeding Between Periods	No	Past	Yes
PMS	No	Past	Yes
Cramps	No	Past	Yes
Abnormal Discharge	No	Past	Yes
Menopausal Symptoms	No	Past	Yes
Number of Pregnancies	______________		
Number of Live Births	______________		
Number of Miscarriages	______________		
Difficulty Conceiving	No	Past	Yes
Are you sexually active?	No	Past	Yes
Birth Control	No	Past	Yes
What type?	______________		
Pain during Intercourse	No	Past	Yes
Venereal Disease	No	Past	Yes
Number of Abortions (optional)	______________		

Male Reproduction

Difficulty Urinating	No	Past	Yes
Prostate Problems	No	Past	Yes
Hernias	No	Past	Yes
Testicular Masses	No	Past	Yes
Testicular Pain	No	Past	Yes
Are you sexually active?	No	Past	Yes
Birth Control	No	Past	Yes
What Type?	______________		
Sexual Difficulties	No	Past	Yes
Venereal Disease	No	Past	Yes
Discharge or Sores	No	Past	Yes

Optional Question for Both Sexes

Please circle sexual orientation:
Heterosexual
Homosexual
Bisexual
Other ________________________________