Review of Systems

Please have this form completed for your initial visit.

Place a check mark (√) next to the symptoms you are currently experiencing in the “Yes” column & circle the specific symptom.
If you have experienced it in the past, indicate the year(s) in the “Past” column (i.e. 2007, 1997-2001).

Only fill out the areas that are applicable.

Skin

	Yes	Past		Yes	Past
rashes • hives • itching			changes to moles • changes in skin colour		
acne • boils • lumps • bumps			eczema • psoriasis		
dry skin • oily skin			temperature • night sweats		
excessive sweating			hair changes (colour, loss)		
skin ulcers • cancer			nail changes (strength, shape)		

Head

	Yes	Past		Yes	Past
headache • migraines			problems with jaw joint (TMJ)		
head injury • concussion			dizziness		

Eyes

	Yes	Past		Yes	Past
impaired vision • blurring			double vision		
floaters • blind spots			corrective lenses		
sensitivity to light			eye pain • itching • discharge		
glaucoma			excessive tearing • dryness • redness		
cataracts			date of last visit to eye doctor :		

Ear, Nose, Throat, Mouth

	Yes	Past		Yes	Past
ringing in ears (tinnitus)			swollen glands in neck • lumps		
impaired hearing • hearing aids			neck pain • stiffness		
earache • pain • infection			mercury/silver dental fillings		
ruptured ear drum			frequent colds		
excessive ear wax • discharge			nose bleeds		
do you use Q-tips?			allergies • hay fever		
frequent sore throat • hoarseness			sinus pain or congestion		
mouth sores • cankers			sensitive to smells		
gum problems • bleeding					

Blood/Lymphatic

	Yes	Past		Yes	Past
anemia			lymph node swelling		
easy bleeding • bruising			blood transfusions		

Respiratory

	Yes	Past		Yes	Past
cough			asthma • wheezing		
shortness of breath at night			sputum • mucous		
bronchitis • pneumonia			spitting or coughing up blood		
emphysema			pain • difficulty breathing		
tuberculosis					

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Circulatory

	Yes	Past		Yes	Past
heart disease			irregular heart beat • palpitations		
high blood pressure			cyanosis • blueness of lips or nails		
rheumatic fever			cold hands or feet		
heart murmur • defect			varicose veins		
high cholesterol			painful veins • deep leg pain		
angina • chest pain			ankle or leg swelling		

Gastrointestinal

	Yes	Past		Yes	Past
heartburn • acid reflux			belching • gas		
trouble swallowing			bad breath • bad taste in mouth		
change in appetite • thirst			bloating • abdominal pain		
nausea • vomiting			hernia		
blood in stool			mucous or undigested food in stool		
indigestion			diarrhea • constipation		
gallstones • gallbladder removal			rectal bleeding • hemorrhoids • fissures		
ulcer			black tarry stools		

Endocrine

	Yes	Past		Yes	Past
sensitive to cold • cold intolerance			thyroid problems		
sensitive to heat • heat intolerance			low blood sugar (hypoglycemia)		
excessive hunger • thirst			hormone replacement therapy		
diabetes			excessive urination • sweating		
steroid therapy or use					

Musculoskeletal

	Yes	Past		Yes	Past
joint pain • stiffness • arthritis			muscle spasms • cramps		
bone fractures			muscle weakness • tenderness		
ligament sprains • laxity			back pain		
sciatica • nerve pain			osteoporosis • osteopenia		
steroid therapy or use					

Neurological

	Yes	Past		Yes	Past
fainting • loss of consciousness			numbness • tingling • burning		
seizures • convulsions • paralysis			twitching • involuntary movement		
speech impairments • slurring			loss of memory		

Mental/Emotional

	Yes	Past		Yes	Past
mood swings			depression		
excessive stress			sleep difficulties • insomnia		
phobias			thoughts of suicide		
anxiety			treated for substance abuse		

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Urinary

	Yes	Past		Yes	Past
pain or burning while urinating			blood in urine		
inability to hold urine • incontinence			frequent urinary tract infections		
urgency • hesitancy			kidney impairment • stones • infections		

Male Sexual/Reproductive Health

	Yes	Past		Yes	Past
are you sexually active?			sexual orientation (heterosexual • homosexual • other)		
do you use contraception?			penile ulcers • sores		
sexually transmitted infections			penile discharge		
testicular pain • masses			low libido • sexual difficulties		
self testicular exams			erectile dysfunction		
prostate problems			problem with sperm count • motility		

Female Sexual/Reproductive Health

	Yes	Past		Yes	Past
are you sexually active?			sexual orientation (heterosexual • homosexual • other)		
do you use contraception?			age of first period:		
sexually transmitted infections			average # of days of menstrual flow:		
breast lumps • skin puckering			length of cycle (1st day of period to start of next):		
breast tenderness • pain			date of last PAP:		
self breast exams			results of last PAP:		
nipple discharge • changes			list any PMS symptoms:		
breast implants • surgery			number of pregnancies:		
family history of breast cancer			number of live births:		
birth control pill			number of miscarriages or abortions:		
menopause			endometriosis		
year menopausal symptoms began:			ovarian cysts		
bleeding between periods			vaginal itching • redness		
heavy menstrual bleeding			pain during intercourse		
irregular menstrual cycle			vaginal dryness		
vaginal discharge			sexual difficulties		
vaginal infections • yeast • bacterial					

If there are other health concerns or symptoms you feel are important, please use the space below:

Thank you for taking the time to complete this intake form.

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