

**REVIEW OF SYSTEMS**

PATIENT NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

- Do you have vertigo (dizziness)? Yes \_\_\_\_\_ No \_\_\_\_\_
- Do you pass out easily (faint or loss of consciousness)? Yes \_\_\_\_\_ No \_\_\_\_\_
- Do you have double vision or have you lost sight in one eye? Yes \_\_\_\_\_ No \_\_\_\_\_
- Do you have any slurred speech or difficulty with speech? Yes \_\_\_\_\_ No \_\_\_\_\_
- Do you have indigestion or difficulty swallowing? Yes \_\_\_\_\_ No \_\_\_\_\_
- Do you have any difficulty walking, with coordination or falling to one side? Yes \_\_\_\_\_ No \_\_\_\_\_
- Do you have nausea or vomiting? Yes \_\_\_\_\_ No \_\_\_\_\_
- Do you have numbness on one side of your face or body? Yes \_\_\_\_\_ No \_\_\_\_\_
- Do you have any visual disturbances or rapid eye movement? Yes \_\_\_\_\_ No \_\_\_\_\_
- Do you have or have you ever had difficulty in arranging words properly? Yes \_\_\_\_\_ No \_\_\_\_\_
- Do you have a headache or head pain that is unlike any you have had before? Yes \_\_\_\_\_ No \_\_\_\_\_
- Do you have headaches for hours or days? Yes \_\_\_\_\_ No \_\_\_\_\_
- Do you have a history of stroke in your family? Yes \_\_\_\_\_ No \_\_\_\_\_
- Do you have chest pain? Yes \_\_\_\_\_ No \_\_\_\_\_
- Do you have any change in bowel or bladder habits? Yes \_\_\_\_\_ No \_\_\_\_\_
- Do you have a sore that does not heal? Yes \_\_\_\_\_ No \_\_\_\_\_
- Do you have any unusual bleeding or discharge? Yes \_\_\_\_\_ No \_\_\_\_\_
- Do you have any thickening in your breasts or elsewhere? Yes \_\_\_\_\_ No \_\_\_\_\_
- Do you have a change in any wart or mole? Yes \_\_\_\_\_ No \_\_\_\_\_
- Do you have a nagging cough or hoarseness? Yes \_\_\_\_\_ No \_\_\_\_\_
- Do you have night sweats? Yes \_\_\_\_\_ No \_\_\_\_\_
- Do you have pain in neck, jaw or face? Yes \_\_\_\_\_ No \_\_\_\_\_
- Do you have a drooping eyelid or change in your pupils? Yes \_\_\_\_\_ No \_\_\_\_\_
- Do you have any ringing in your ears? Yes \_\_\_\_\_ No \_\_\_\_\_
- Do you take birth control pills? Yes \_\_\_\_\_ No \_\_\_\_\_

What prescription medication are you taking if any?

- High blood pressure medication
- Blood thinners
- Herb, vitamins, or over the counter products
- Other \_\_\_\_\_

- Have you ever had cancer? Yes \_\_\_ No \_\_\_
- Does you pain ever wake you from a sound sleep? Yes \_\_\_ No \_\_\_
- Are you losing weight now without trying? Yes \_\_\_ No \_\_\_
- Are you coughing up blood or noticing it in your stools or urine? Yes \_\_\_ No \_\_\_
- Have you had any loss of bladder or bowel control? Yes \_\_\_ No \_\_\_
- Have you lost consciousness or had double vision recently? Yes \_\_\_ No \_\_\_
- Are you seeing any other doctor now for any reason? Yes \_\_\_ No \_\_\_

Note: \_\_\_\_\_

Are you taking any medication or over-the-counter drugs? Yes \_\_\_ No \_\_\_

Please indicate type (aspirin, etc.) \_\_\_\_\_

Are you taking herbs, nutraceuticals, botanicals, or vitamins?

Please list \_\_\_\_\_

What was the date of onset of your last menses? \_\_\_\_\_

**Social History**

SMOKER Yes \_\_\_ No \_\_\_ If **Yes**, how many packs \_\_\_\_\_

ALCOHOL Yes \_\_\_ No \_\_\_ If **Yes**, how much \_\_\_\_\_

**Family History**

Did you mother or father have any of the following:

Put an **M** for mother, **F** for father, and **B** for both.

- High Blood Pressure
- Heart Attack
- Emphysema
- Seizure-Convulsions
- HIV Positive
- Asthma
- Diabetes
- Kidney Disease
- Ulcer or Stomach Problems
- Stroke (Please indicate age when stroke occurred, Mother \_\_\_\_\_ Father \_\_\_\_\_)
- Arthritis-Rheumatism
- Mental Illness
- Thyroid Disease
- Circulation Problems
- Cancer