

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

## HEALTH SYMPTOM HISTORY - REVIEW OF SYSTEMS

Please circle YES for current symptoms, PAST for symptoms you've had in the past,  
or NO for symptoms you have never had.

### General Health

Weight - \_\_\_\_\_  
 Weight 1 year ago - \_\_\_\_\_  
 Maximum Weight - \_\_\_\_\_  
 When? - \_\_\_\_\_  
 Height - \_\_\_\_\_  
 Night Sweats - Yes No Past  
 Fatigue - Yes No Past  
 Date of Last Physical - \_\_\_\_\_

#### Neck

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

#### Blood

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

#### Respiratory

Cough	- Yes No Past
Spitting up Blood	- Yes No Past
Wheezing	- Yes No Past
Difficulty Breathing	- Yes No Past
Pain on Breathing	- Yes No Past
Shortness of Breath	- Yes No Past
Shortness of Breath Lying Down	- Yes No Past
Shortness of Breath at Night	- Yes No Past
Positive TB Test	- Yes No Past

#### Skin

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

#### Head

Headache	- Yes No Past
Head Injury	- Yes No Past

#### Eyes

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

#### Ears

Impaired Hearing	- Yes No Past
Ringing	- Yes No Past
Earache/Itch	- Yes No Past
Dizziness	- Yes No Past

#### Nose & Sinuses

Frequent Colds	- Yes No Past
Nose Bleeds	- Yes No Past
Stiffness	- Yes No Past

#### Mouth and Throat

Frequent Sore Throat	- Yes No Past
Sore Tongue	- Yes No Past
Sores in Mouth/on Lips	- Yes No Past
Gum Problems	- Yes No Past
Hoarseness	- Yes No Past
Dental Problems	- Yes No Past

#### Heart

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

#### Digestion

Trouble Swallowing	- Yes No Past
Heartburn	- Yes No Past
Stomach Pain	- Yes No Past
Change in Thirst	- Yes No Past
Change in Appetite	- Yes No Past
Nausea	- Yes No Past
Vomiting	- Yes No Past
Bowels Move	- Daily More Less
Loose Stools	- Yes No Past
Is this a change?	- Yes No Past
Blood in Stools	- Yes No Past
Belching or Gas	- Yes No Past
Liver/Gall Bladder Disease	- Yes No Past
Hemorrhoids	- Yes No Past

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# Symptom History

Please respond to the following by circling Yes for current symptoms, Past for symptoms you've had in the past, or No for symptoms you have never had.

## General Health (continued)

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

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

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

## Urinary

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

## Circulation

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

## Neurologic

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

## Male Reproduction

Hernias	Yes	No	Past
Testicular Masses	Yes	No	Past
Testicular Pain	Yes	No	Past
Are you sexually active?	Yes	No	Past
Birth Control	Yes	No	Past
What type?			
Sexual Difficulties	Yes	No	Past
Prostate Problems	Yes	No	Past
Veneral Disease	Yes	No	Past
Discharge or Sores	Yes	No	Past
Difficulty Stopping/Starting Urination	Yes	No	Past

## Optional Question for Both Sexes

Please indicate sexual preference:

Heterosexual	-
Bisexual	-
Homosexual	-

## Female Reproduction

Breasts- Do you self exam regularly?	Yes	No	Past
Lumps	Yes	No	Past
Pain or Tenderness	Yes	No	Past
Nipple Discharge	Yes	No	Past

## Female Reproduction (continued)

Date of Last Menstrual Period	-		
Age Menses Began	-		
Days of Menstrual Flow	-		
Days Between Cycles	-		
Are your cycles regular?	Yes	No	Past
Excessive Flow	Yes	No	Past
Bleeding Between Periods	Yes	No	Past
PMS	Yes	No	Past
Cramps	Yes	No	Past
Abnormal Vaginal Discharge	Yes	No	Past
Menopausal Symptoms	Yes	No	Past
Number of Pregnancies	Yes	No	Past
Number of Live Births	Yes	No	Past
Number of Miscarriages	Yes	No	Past
Difficulty Conceiving	Yes	No	Past
Are you sexually active?	Yes	No	Past
Birth Control	Yes	No	Past
What type?			
Pain During Intercourse	Yes	No	Past
Veneral Disease	Yes	No	Past
Number of Abortions (optional)	-		