Review of Systems – (Check box if you have had trouble with any of the following)

Cardiovascular			**Respiratory**			**Allergic/Immunologic**		
	Past	Present		Past	Present		Past	Present
Poor Circulation			Asthma			Hives		
Hypertension			Tuberculosis			Immune Disorder		
Aortic Aneurism			Short Breath			HIV/AIDS		
Heart Disease			Emphysema			Allergy Shots		
Heart Attack			Cold/Flu			Cortisone Use		
Chest Pain			Cough					
High Cholesterol			Wheezing					
Pace Maker						**Ear, Nose and Throat**		
Jaw Pain			**Eyes**				Past	Present
Irregular Heartbeat				Past	Present	Difficulty Swallowing		
Swelling of legs			Glaucoma			Dizziness		
			Double Vision			Hearing Loss		
Genitourinary			Blurred Vision			Sore Throat		
	Past	Present				Nosebleeds		
Kidney Disease			**Psychiatric**			Bleeding Gums		
Burning Urination				Past	Present	Sinus Infections		
Frequent Urination			Depression					
Blood in Urine			Anxiety			**Gastrointestinal**		
Kidney Stones			Stress				Past	Present
Lower Side Pain						Gall Bladder Problems		
			Endocrine			Bowel Problems		
Neurologic				Past	Present	Constipation		
	Past	Present	Thyroid			Liver Problems		
Stroke			Diabetes			Ulcers		
Seizures			Hair Loss			Diarrhea		
Head Injury			Menopausal			Nausea/Vomiting		
Brain Aneurysm			PMS			Bloody Stools		
Numbness						Poor Appetite		
Severe Headaches			**Hematologic**					
Pinched Nerves				Past	Present	**Musculoskeletal**		
Parkinson's			Hepatitis				Past	Present
Carpal Tunnel			Blood Clots			Gout		
Vertigo			Cancer			Arthritis		
Bowl or Bladder Changes			Bruising			Joint Stiffness		
Constitutional			Bleeding			Muscle Weakness		
	Past	Present	Fever, Chills			Osteoporosis		
			Sweating			Broken Bones		
Weight Loss/Gain			Varicose Vein			Joints Replaced		
Low Energy Level						Neck Pain		
Difficulty Sleeping						Low Back Pain		
						Upper Back Pain		

Medical Conditions: (Circle all that apply to you) or **N/A** (If nothing applies)

Arthritis	Cancer	Diabetes	Heart Disease
Hypertension	Psychiatric Illness	Skin Disorder	Stroke
Other _____	Fibromyalgia	Asthma	Osteoporosis

Surgeries: (Circle all that apply to you) or **N/A** (If nothing applies)

Appendectomy	Cardiovascular procedure	Cervical spine	Hysterectomy
Joint Replacement	Prostate	Lumbar spine	Gall Bladder
Brain	Shoulder	Thoracic spine	Knee
Carpal Tunnel	Gastro-intestinal	Uro-genital	Hernia
Breast Augmentation	Other _____		

Social History: (Circle all that apply to you) or **N/A** (If nothing applies)

Caffeine use:	occasional	often	never
Drink Alcohol:	occasional	often	never
Exercise:	occasional	often	never
Drink Water:	<64 oz/day	>64 oz/day	never
Cigarettes:	<1 pack/day	>1 pack/day	never
Sleep:	<8 hours/night	>=8 hours/night	Insomnia

Other _____

Family History: (Circle all that apply) or **N/A** (If nothing applies)

Arthritis:	Grandparent	Parent	Sibling
Cancer:	Grandparent	Parent	Sibling
Diabetes:	Grandparent	Parent	Sibling
Heart Disease	Grandparent	Parent	Sibling
Hypertension	Grandparent	Parent	Sibling
Stroke	Grandparent	Parent	Sibling
Thyroid	Grandparent	Parent	Sibling

Other _____

Please list any Allergies to Medications or Substances_____

_____

Please list all current Medications being taken _____

_____

Are You Pregnant? Yes No

Do you experience pain every day? Yes No

Do your symptoms interfere with your daily life? Yes No

Does your pain wake you up at night? Yes No

Are your symptoms worse during certain times of the day? Yes No