Holistic Healing Arts
REVIEW OF SYSTEMS

Name: _____ **Date:** _____

Y A condition you have now
N A condition you have NEVER had
P A condition you have had in the past

Responses and Comments:

1. GENERAL					
	Weight				
	Weight 1 year ago				
	Maximum weight				
	When				
	Height				
	Fatigue/Weakness	Y	P	N	
	Fever/Chills	Y	P	N	

2. SKIN					
	Rashes	Y	P	N	
	Eczema, hives	Y	P	N	
	Acne, boils	Y	P	N	
	Itching	Y	P	N	
	Color change	Y	P	N	
	Lumps	Y	P	N	
	Night sweats	Y	P	N	
	Dryness/Moistness	Y	P	N	
	Temperature	Y	P	N	
	Nail changes	Y	P	N	
	Change in Mole	Y	P	N	
	Skin Cancer	Y	P	N	

3. HEAD					
	Headache	Y	P	N	
	Head injury	Y	P	N	

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	Dizziness	Y	P	N	

4. EYES					
	Impaired vision	Y	P	N	
	Glasses/Contacts	Y	P	N	
	Eye pain	Y	P	N	
	Tearing or dryness	Y	P	N	
	Double vision	Y	P	N	
	Glaucoma	Y	P	N	
	Cataracts	Y	P	N	
	Blurring	Y	P	N	
	Bothered by sun	Y	P	N	
	Itching	Y	P	N	
	Redness	Y	P	N	
	Discharge	Y	P	N	
	Blind spot	Y	P	N	

5. EARS					
	Impaired hearing	Y	P	N	
	Earache	Y	P	N	
	Dizziness	Y	P	N	
	Discharge	Y	P	N	
	Infections	Y	P	N	

6. NOSE & SINUSES					
	Frequent colds	Y	P	N	
	Nose bleeds	Y	P	N	
	Stuffiness	Y	P	N	
	Hay fever	Y	P	N	
	Sinus problems	Y	P	N	

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7. MOUTH & THROAT					
	Frequent sore throat	Y	P	N	
	Sore tongue/mouth	Y	P	N	
	Gum problems	Y	P	N	
	Hoarseness	Y	P	N	
	Dental cavities	Y	P	N	
	Loss of taste	Y	P	N	

8. NECK					
	Lumps	Y	P	N	
	Swollen glands	Y	P	N	
	Goiter	Y	P	N	
	Pain or stiffness	Y	P	N	

9. RESPIRATORY					
	Cough	Y	P	N	
	Sputum	Y	P	N	
	Spitting up blood	Y	P	N	
	Wheezing	Y	P	N	
	Asthma	Y	P	N	
	Bronchitis	Y	P	N	
	Pneumonia	Y	P	N	
	Pleurisy	Y	P	N	
	Emphysema	Y	P	N	
	Difficulty breathing	Y	P	N	
	Pain on breathing	Y	P	N	
	Shortness of breath	Y	P	N	
	Shortness of breath at night	Y	P	N	
	Shortness of breath lying down	Y	P	N	

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	Tuberculosis	Y	P	N	
	Tuberculin Test	Y	P	N	
	Last Chest X-ray				

10. CARDIOVASCULAR					
	Heart disease	Y	P	N	
	Angina	Y	P	N	
	High blood pressure	Y	P	N	
	Murmurs	Y	P	N	
	Rheumatic fever	Y	P	N	
	Chest pain	Y	P	N	
	Swelling in ankles	Y	P	N	
	Palpitations, fluttering	Y	P	N	
	Cyanosis	Y	P	N	
	Past ECG	Y	P	N	
	Other heart tests				

11. BREASTS					
	Do you do self exams?	Y	P	N	
	Lumps	Y	P	N	
	Pain (or tenderness)	Y	P	N	
	Nipple discharge	Y	P	N	

12. GASTROINTESTINAL					
	Trouble swallowing	Y	P	N	
	Heartburn	Y	P	N	
	Change in thirst	Y	P	N	
	Change in appetite	Y	P	N	
	Nausea	Y	P	N	
	Vomiting	Y	P	N	
	Vomiting blood	Y	P	N	

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	Bowel movements - How often?				
	Is this a change?	Y		N	
	Blood in stool	Y	P	N	
	Belching or passing gas	Y	P	N	
	Jaundice (yellow skin)	Y	P	N	
	Liver disease	Y	P	N	
	Gall Bladder disease	Y	P	N	
	Ulcer	Y	P	N	
	Indigestion	Y	P	N	
	Diarrhea	Y	P	N	
	Rectal bleeding	Y	P	N	
	Hemorrhoids	Y	P	N	
	Black, tarry stool	Y	P	N	
	Abdominal pain	Y	P	N	
	Food allergy	Y	P	N	
	Hernias	Y	P	N	

13. URINARY					
	Pain on urination	Y	P	N	
	Increased frequency	Y	P	N	
	Frequency at night	Y	P	N	
	Inability to hold urine	Y	P	N	
	Frequent infections	Y	P	N	
	Kidney stones	Y	P	N	
	Blood in urine	Y	P	N	
	Urgency	Y	P	N	
	Hesitancy	Y	P	N	

14. MALE REPRODUCTIVE					
	Hernias	Y	P	N	

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	Testicular masses	Y	P	N	
	Testicular pain	Y	P	N	
	Are you sexually active?	Y	P	N	
	Sexual difficulties	Y	P	N	
	Venereal disease	Y	P	N	
	Discharge or sores	Y	P	N	

15. FEMALE REPRODUCTIVE					
	Age menses began				
	Average number of days				
	Length of cycle				
	Bleeding between periods	Y	P	N	
	Are cycles regular	Y	P	N	
	Pain during intercourse	Y	P	N	
	Painful menses	Y	P	N	
	Excessive flow	Y	P	N	
	PMS	Y	P	N	
	Birth control?	Y	P	N	
	What type?				
	Number of pregnancies				
	Number of live births				
	Number of miscarriages				
	Number of abortions				
	Difficulty conceiving	Y	P	N	
	Are you sexually active?	Y	P	N	
	Sexual difficulties	Y	P	N	
	Venereal Disease	Y	P	N	
	Last menstrual period				
	Vaginal discharge	Y	P	N	
	Vaginal itching	Y	P	N	
	Last PAP - (date)				

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16. MUSCULOSKELETAL					
	Joint pain or stiffness	Y	P	N	
	Arthritis	Y	P	N	
	Broken bones	Y	P	N	
	Muscle spasms or cramps	Y	P	N	
	Weakness	Y	P	N	
	Joint swelling	Y	P	N	
	Backache	Y	P	N	

17. PERIPHERAL VASCULAR					
	Deep leg pain	Y	P	N	
	Cold hands/feet	Y	P	N	
	Varicose veins	Y	P	N	
	Thrombophlebitis	Y	P	N	
	Leg cramps	Y	P	N	
	Extremity numbness	Y	P	N	
	Extremity coldness	Y	P	N	
	Extremity swelling	Y	P	N	
	Extremity ulcers	Y	P	N	

18. NEUROLOGIC					
	Fainting	Y	P	N	
	Seizures/Convulsions	Y	P	N	
	Paralysis	Y	P	N	
	Muscle weakness	Y	P	N	
	Numbness or tingling	Y	P	N	
	Loss of memory	Y	P	N	
	Involuntary movement	Y	P	N	
	Loss of balance	Y	P	N	
	Speech problems	Y	P	N	

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19. ENDOCRINE					
	Heat or cold intolerance	Y	P	N	
	Thyroid trouble	Y	P	N	
	Excessive thirst	Y	P	N	
	Excessive hunger	Y	P	N	
	Excessive urination	Y	P	N	
	Excessive sweating	Y	P	N	
	Diabetes	Y	P	N	
	Hypoglycemia	Y	P	N	
	Hormone therapy	Y	P	N	

20. BLOOD/LYMPHATIC					
	Anemia	Y	P	N	
	Easy bleeding or bruising	Y	P	N	
	Past transfusions	Y	P	N	
	Lymph node swelling	Y	P	N	

20. ALLERGIC HISTORY					
	Drug sensitivity	Y	P	N	
	Reaction to vaccine	Y	P	N	
	Allergies? Please list:				

21. EMOTIONAL					
	Depression	Y	P	N	
	Mood swings	Y	P	N	
	Anxiety or nervousness	Y	P	N	
	Tension	Y	P	N	
	Phobias	Y	P	N	
	Alcohol/Drug abuse	Y	P	N	
	Insomnia	Y	P	N	

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22. HOBBIES/HABITS - Please answer yes (Y) or no (N)				
	Do you eat three meals daily?	Y	N	What are your main interests and hobbies?
	Do you awake rested?	Y	N	Please list:
	Do you sleep well?	Y	N	
	Do you average 6-8 hours sleep?	Y	N	
	Do you enjoy your work?	Y	N	
	Do you watch television?	Y	N	
	How many hours/day?			
	Do you read?	Y	N	
	Do you exercise?	Y	N	
	What forms?			
	How many times/week?			
	Do you take vacations?	Y	N	
	Have you been treated for drug dependence?	Y	N	
	Do you use recreational drugs?	Y	N	
	Do you use alcoholic beverages?	Y	N	
	Have you been treated for alcoholism?	Y	N	
	How often?			