



Review of Systems

Insight Naturopathic Clinic

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 tel: (416) 322-9980

www.insightnaturopathic.com

Name: _____

Date: _____

Y = condition you have NOW **P** = condition you had in the PAST **Skip** if you have NEVER had it

| | | | | | | | | | | | |
|--------------------------------|--|--|--|---|-----------------|---------------|--|--|--|---|---|
| 01. GENERAL | | | | | | | | | | | |
| Current Weight: | | | | | Current Height: | | | | | | |
| Weight 1 year ago | | | | | | | | | | | |
| Maximum weight (NOT pregnant): | | | | | When?: | | | | | | |
| Fatigue, weakness | | | | Y | P | Fever, chills | | | | Y | P |
| Comments: | | | | | | | | | | | |

| | | | | | | | | | | | |
|-----------------------------|--|--|--|---|---|----------------|--|--|--|---|---|
| 02. SKIN & NAILS | | | | | | | | | | | |
| Acne, boils | | | | Y | P | Moistness | | | | Y | P |
| Colour changes | | | | Y | P | Change in mole | | | | Y | P |
| Dryness | | | | Y | P | Rash | | | | Y | P |
| Eczema | | | | Y | P | Skin Cancer | | | | Y | P |
| Itching | | | | Y | P | | | | | | |
| Lumps | | | | Y | P | Nail changes | | | | Y | P |
| Comments: | | | | | | | | | | | |

| | | | | | | | | | | | |
|------------------|--|--|--|---|---|-------------|--|--|--|---|---|
| 03. HEAD | | | | | | | | | | | |
| Dizziness | | | | Y | P | Head injury | | | | Y | P |
| Headache | | | | Y | P | | | | | | |
| Comments: | | | | | | | | | | | |

| | | | | | | | | | | | |
|---------------------------|--|--|--|---|---|--|--|--|--|---|---|
| 04. EYES | | | | | | | | | | | |
| Impaired vision | | | | Y | P | Blind spot | | | | Y | P |
| Glasses or contact lenses | | | | Y | P | Cataracts | | | | Y | P |
| Eye pain | | | | Y | P | Discharge | | | | Y | P |
| Dryness | | | | Y | P | Double vision | | | | Y | P |
| Itching | | | | Y | P | Glaucoma | | | | Y | P |
| Redness | | | | Y | P | Photosensitivity (bothered by the sun) | | | | Y | P |
| Tearing | | | | Y | P | | | | | | |
| Comments: | | | | | | | | | | | |



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| 05. EARS | | | | | |
|------------------|---|---|------------------|---|---|
| Discharge | Y | P | Dizziness | Y | P |
| Earaches | Y | P | Impaired hearing | Y | P |
| Infections | Y | P | | | |
| Comments: | | | | | |

| 06. NOSE & SINUSES | | | | | |
|--------------------|---|---|--------------------------------------|---|---|
| Nose bleeds | Y | P | Sinus problems | Y | P |
| Stiffness | Y | P | Allergies (hay fever, ragweed, etc.) | Y | P |
| Frequent colds | Y | P | | | |
| Post-nasal drip | Y | P | | | |
| Comments: | | | | | |

| 07. MOUTH & THROAT | | | | | |
|--------------------|---|---|-----------------------|---|---|
| Sore mouth | Y | P | Sore tongue | Y | P |
| Gum problems | Y | P | Loss of taste | Y | P |
| Dental cavities | Y | P | Frequent sore throats | Y | P |
| Hoarseness | Y | P | | | |
| Comments: | | | | | |

| 08. NECK | | | | | |
|------------------|---|---|----------------|---|---|
| Pain | Y | P | Lumps | Y | P |
| Stiffness | Y | P | Goiter | Y | P |
| | | | Swollen glands | Y | P |
| Comments: | | | | | |

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| 09. RESPIRATORY SYSTEM | | | | | |
|-------------------------------------|---|---|-------------------------------|---|---|
| Cough | Y | P | Asthma | Y | P |
| Difficulty breathing | Y | P | Bronchitis | Y | P |
| Pain on breathing | Y | P | Emphysema | Y | P |
| Shortness of breath | Y | P | Pleurisy | Y | P |
| Shortness of breath at night | Y | P | Pneumonia | Y | P |
| Shortness of breath when lying down | Y | P | Tuberculosis | Y | P |
| Spitting up blood | Y | P | Tuberculin Test (Date:) | Y | P |
| Sputum | Y | P | Previous chest x-ray (Date:) | Y | P |
| Wheezing | Y | P | | | |
| Comments: | | | | | |

| 10. CARDIOVASCULAR SYSTEM | | | | | |
|--------------------------------|---|---|-----------------------|---|---|
| Chest pain | Y | P | Angina | Y | P |
| Cyanosis | Y | P | Low blood pressure | Y | P |
| Murmur(s) | Y | P | High blood pressure | Y | P |
| Palpitations, heart fluttering | Y | P | Heart disease | Y | P |
| Swelling in ankles | Y | P | Rheumatic fever | Y | P |
| | | | Previous ECG (Date:) | Y | P |
| Comments: | | | | | |

| 11. Peripheral Vascular System | | | | | |
|--|---|---|-------------------------------|---|---|
| Extremity coldness (hands and/or feet) | Y | P | Raynaud's syndrome or disease | Y | P |
| Extremity numbness | Y | P | Thrombophlebitis | Y | P |
| Extremity swelling | Y | P | Varicose veins | Y | P |
| Extremity ulcers | Y | P | | | |
| Leg cramps | Y | P | | | |
| Deep leg pain | Y | P | | | |
| Comments: | | | | | |

| 12. Blood or Lymphatic System | | | | | |
|-------------------------------|---|---|---------------------|---|---|
| Easy bleeding or bruising | Y | P | Lymph node swelling | Y | P |
| Anemia | Y | P | | Y | P |
| Previous transfusion (Date:) | Y | P | | | |
| Comments: | | | | | |

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13. Gastrointestinal System

| | | | | | |
|-----------------------------|---|-------------|------------------------|---|---|
| Change in appetite | Y | P | Food allergy | Y | P |
| Change in thirst | Y | P | Heartburn | Y | P |
| Trouble swallowing | Y | P | Vomiting | Y | P |
| Nausea | Y | P | Vomiting blood | Y | P |
| Belching and/or passing gas | Y | P | Indigestion | Y | P |
| Abdominal pain | Y | P | Hernia | Y | P |
| Bowel movements | Y | P | Ulcer | Y | P |
| # per day: | | # per week: | Diarrhea | Y | P |
| Is this a change? | Y | P | Hemorrhoids | Y | P |
| Rectal bleeding | Y | P | Jaundice (yellow skin) | Y | P |
| Blood in stools | Y | P | Liver disease | Y | P |
| Black and/or tarry stools | Y | P | Gallbladder disease | Y | P |
| Comments: | | | | | |

14. Urinary System

| | | | | | |
|------------------------------|---|---|------------------------------------|---|---|
| Blood in urine | Y | P | Urinary incontinence | Y | P |
| Increased frequency | Y | P | Urinary tract infection | Y | P |
| Increased frequency at night | Y | P | Frequent urinary tract infections? | Y | P |
| Hesitancy | Y | P | # per year: | | |
| Pain on urination | Y | P | Kidney stones | Y | P |
| Urgency | Y | P | | | |
| Comments: | | | | | |

15. Male Reproductive System

| | | | | | |
|-------------------------------------|---|---|---|---|---|
| Hernia | Y | P | Fertility difficulties | Y | P |
| Testicular mass(es) | Y | P | Sexual difficulties | Y | P |
| Testicular pain | Y | P | Are you sexually active? | Y | P |
| Penile discharge | Y | P | Sexually transmitted disease(s) | Y | P |
| Sore(s) on penis and/or testicle(s) | Y | P | Sexual preference: heterosexual bisexual homosexual | | |
| Comments: | | | | | |



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| 16. Female Reproductive System | | | | | |
|---|---|---|--|---|---|
| Age that menses began: | | | Do you do self-breast exams regularly? | Y | P |
| Average # of days of bleeding: | | | Breast pain and/or tenderness | Y | P |
| Length of cycle: | | | Breast lump(s) | Y | P |
| Last menstrual period: | | | Nipple discharge | Y | P |
| Regular menstrual cycles? | Y | P | # of pregnancies: | | |
| Bleeding between periods | Y | P | # of live births: | | |
| Excessive menstrual flow | Y | P | # of miscarriages: | | |
| PMS | Y | P | # of abortions: | | |
| Painful menses | Y | P | Birth control (Type: _____) | Y | P |
| Vaginal discharge | Y | P | Fertility difficulties | Y | P |
| Vaginal itching | Y | P | Sexual difficulties | Y | P |
| Previous PAP exam (Date: _____) | Y | P | Are you sexually active? | Y | P |
| Sexual preference: heterosexual bisexual homosexual | | | Sexually transmitted disease(s) | Y | P |
| Comments: | | | | | |

| 17. EMOTIONAL | | | | | |
|----------------------|---|---|-----------------------------|---|---|
| Anxiety | Y | P | Insomnia | Y | P |
| Mood swings | Y | P | Depress | Y | P |
| Nervousness | Y | P | Mania | Y | P |
| Tension | Y | P | Phobia(s) (List: _____) | Y | P |
| | | | Addiction(s) (List: _____) | | |
| Comments: | | | | | |

| 18. ENDOCRINE SYSTEM | | | | | |
|-----------------------------|---|---|-----------------|---|---|
| Cold or heat intolerance | Y | P | Diabetes | Y | P |
| Excessive hunger | Y | P | Hypoglycemia | Y | P |
| Excessive thirst | Y | P | Hypothyroidism | Y | P |
| Excessive urination | Y | P | Hyperthyroidism | Y | P |
| Excessive sweating | Y | P | Hormone therapy | Y | P |
| Comments: | | | | | |

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|-----------------------------|------------------------|---|---|-----------------|---|---|
| 19. Allergic History | | | | | | |
| | Drug sensitivity | Y | P | Other allergies | Y | P |
| | Reaction to vaccine(s) | Y | P | (List: _____) | | |
| Comments: | | | | | | |
| | | | | | | |

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|--------------------------------|--------------------------|---|---|-----------------------|---|---|
| 20. NEUROLOGICAL SYSTEM | | | | | | |
| | Loss of balance | Y | P | Alzheimer's disease | Y | P |
| | Involuntary movement(s) | Y | P | Convulsions, seizures | Y | P |
| | Loss of memory | Y | P | Fainting | Y | P |
| | Muscle weakness | Y | P | Nerve pain | Y | P |
| | Numbness and/or tingling | Y | P | Paralysis | Y | P |
| | Speech problems | Y | P | Parkinson's disease | Y | P |
| Comments: | | | | | | |
| | | | | | | |

| | | | | | | |
|-----------------------------------|-----------------------------|---|---|-----------------------------|---|---|
| 21. MUSCULOSKELETAL SYSTEM | | | | | | |
| | Backache | Y | P | Arthritis | Y | P |
| | Broken bone(s) | Y | P | Osteoarthritis | Y | P |
| | Joint pain and/or stiffness | Y | P | Rheumatoid arthritis | Y | P |
| | Joint swelling | Y | P | Muscle cramps and/or spasms | Y | P |
| | Weakness | Y | P | | | |
| Comments: | | | | | | |
| | | | | | | |

| | | | | | | |
|---|--|---|---|---|---|---|
| 22. HOBBIES & HABITS | | | | | | |
| | Do you eat 3 meals per day? | Y | P | Do you enjoy your work? | Y | P |
| | Do you drink alcohol? | Y | P | Do you take vacations? | Y | P |
| | # per day: # per week: | | | Do you read? | Y | P |
| | Previous treatment for alcoholism | Y | P | Do you watch tv? | Y | P |
| | Do you sleep well? | Y | P | hours per day: hours per week: | Y | P |
| | Do you average 6-8 hours of sleep per night? | Y | P | Do you exercise? | Y | P |
| | Do you awake feeling rested? | Y | P | types: | | |
| | Do you have trouble falling back asleep? | Y | P | # of times per week: | | |
| | Do you smoke? | Y | P | Do you use recreational drugs? | Y | P |
| | # per day: since: | | | # of times per day: since: | | |
| | Previous attempt to quit smoking | Y | P | Previous treatment for drug dependence | Y | P |
| What are your main interests and hobbies? | | | | | | |
| Comments: | | | | | | |
| | | | | | | |