NURTURING HEALTH
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REVIEW OF SYSTEMS

Please circle:

Y A condition or symptom that you have NOW
N A condition or symptom that you have NEVER had
P A condition or symptom that you have had in the PAST

	Please circle one			*Responses & 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	
Colour change	Y	P	N	
Lumps or abscesses	Y	P	N	
Night sweats	Y	P	N	
Excessive perspiration	Y	P	N	
Strong body odour	Y	P	N	
Dryness/moistness	Y	P	N	
Temperature	Y	P	N	
Brittle nails	Y	P	N	
Changes in mole	Y	P	N	
Skin cancer	Y	P	N	
Frequent Sunburns	Y	P	N	
Warts	Y	P	N	
Hemorrhoids	Y	P	N	
Varicose Veins	Y	P	N	

3. HEAD				
Headache or migraines	Y	P	N	
Head injury	Y	P	N	
Dizziness	Y	P	N	

4. EYES				
Impaired vision	Y	P	N	
Poor night vision	Y	P	N	
Double vision	Y	P	N	
Eye pain	Y	P	N	
Tearing or dryness	Y	P	N	
Glaucoma	Y	P	N	

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Cataracts	Y	P	N	
Blurring	Y	P	N	
Bothered by sun	Y	P	N	
Itching	Y	P	N	
Glasses/contacts	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	
Ringing in ears	Y	P	N	
Dizziness	Y	P	N	
Discharge	Y	P	N	
Infections	Y	P	N	

6. NOSE and 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	
Postnasal drip	Y	P	N	

7. MOUTH and THROAT				
Frequent sore throat	Y	P	N	
Sore tongue and mouth	Y	P	N	
Gum problems	Y	P	N	
Frequent cold sores	Y	P	N	
Hoarseness	Y	P	N	
Dental cavities	Y	P	N	
Loss of taste	Y	P	N	
Jaw pain and clicking	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				
Chronic cough	Y	P	N	
Sputum	Y	P	N	
Spitting up blood	Y	P	N	
Chronic phlegm	Y	P	N	
Wheezing	Y	P	N	
Asthma	Y	P	N	
Bronchitis	Y	P	N	
Pneumonia	Y	P	N	
Emphysema	Y	P	N	

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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	
Tuberculosis	Y	P	N	
Tuberculin test	Y	P	N	
Last chest x-ray?	Y	P	N	

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	
Dizziness on standing	Y	P	N	
Cyanosis	Y	P	N	
Past ECG	Y	P	N	
Other heart tests	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	
Bowel movements – How often?				
Is this a change?	Y	P	N	
Blood in stool	Y	P	N	
Itching around anus				
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	
Black, tarry stool	Y	P	N	
Abdominal pain	Y	P	N	
Food allergy	Y	P	N	
Hernias	Y	P	N	
History of parasites	Y	P	N	
History of disordered eating	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 bladder 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	
Prostate conditions	Y	P	N	
When was your last prostate exam?				
Testicular masses	Y	P	N	
Testicular pain	Y	P	N	
Are you sexually active?	Y	P	N	
Sexual difficulties	Y	P	N	
Low sex drive	Y	P	N	
Venereal disease	Y	P	N	
Discharge or sores	Y	P	N	
Sexual preference: Heterosexual	Y	P	N	
Bisexual	Y	P	N	
Homosexual	Y	P	N	

11. BREASTS				
Do you perform self-exams?	Y	P	N	
When was your last clinical breast exam?				
When was your last mammogram?				
Fibrocystic breasts	Y	P	N	
Breast lumps or cysts	Y	P	N	
Pain (or tenderness)	Y	P	N	
Nipple discharge	Y	P	N	

15. FEMALE REPRODUCTIVE				
Age of first menses?				
Age of last menses (if applicable)?				
Average number of days your period lasts:				
Length of cycle:				
Date of last menstrual period (LMP)?				
Bleeding between periods	Y	P	N	
Are cycles regular	Y	P	N	
Are cycles irregular	Y	P	N	
Painful menses or cramping	Y	P	N	
Excessive flow	Y	P	N	
Missed periods	Y	P	N	

If so, how long have you gone without a period?				
PMS	Y	P	N	
What PMS symptoms do you experience?				
Birth control?	Y	P	N	
What type? Duration of use?				
Are you currently pregnant?				
Are you currently trying to conceive?				
Number of pregnancies:				
Number of live births:				
Number of miscarriages:				
Number of abortions:				
Ectopic or tubal pregnancy	Y	P	N	
Complications of pregnancy	Y	P	N	
Please describe:				
Difficulty conceiving	Y	P	N	
If yes, please indicate how many months/years trying to conceive:				
Fertility treatment	Y	P	N	
Please describe:				
Are you sexually active?	Y	P	N	
Sexual difficulties	Y	P	N	
Pain during intercourse	Y	P	N	
Frequent yeast infections	Y	P	N	
Abnormal vaginal discharge	Y	P	N	
If yes, please describe (colour, consistency, odour):				
Vaginal Itching	Y	P	N	
Endometriosis	Y	P	N	
Uterine fibroids	Y	P	N	
Ovarian cysts	Y	P	N	
Ovarian tumors	Y	P	N	
Chlamydia	Y	P	N	
Gonorrhea	Y	P	N	
Syphilis	Y	P	N	
Herpes	Y	P	N	
Trichomonas	Y	P	N	
Pelvic Inflammatory Disease	Y	P	N	
Sexual preference: Heterosexual	Y	P	N	
Bisexual	Y	P	N	
Homosexual	Y	P	N	
Date of last gynecologic exam:				
Date of PAP:				
History of abnormal PAP	Y	P	N	
If so, what grade and how was it treated?				
Menopausal symptoms	Y	P	N	
Which menopausal symptoms are you currently experiencing?				

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	

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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 or spasms	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	
Dizziness or vertigo	Y	P	N	

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/LYMPATIC				
Anemia	Y	P	N	
Easy bleeding or bruising	Y	P	N	
Past transfusions	Y	P	N	
Lymph node swelling	Y	P	N	

21. ALLERGIC HISTORY				
Drug sensitivity	Y	P	N	
Reaction to vaccine	Y	P	N	
Reaction to food	Y	P	N	

22. EMOTIONAL				
Depression	Y	P	N	
Mood swings	Y	P	N	
Anxiety or nervousness	Y	P	N	
Panic Attacks	Y	P	N	
Tension	Y	P	N	
Phobias	Y	P	N	
Insomnia	Y	P	N	
Mental Illness	Y	P	N	

23. HOBBIES/HABITS			
Please answer yes (Y) or no (N)			
Do you eat 3 meals daily?	Y	N	
Any dietary restrictions (i.e. vegetarian, vegan, religious) ?			
Do you awake rested?	Y	N	
Do you sleep well?	Y	N	
Do you average 6-8 hours sleep?	Y	N	
Do you enjoy your work?	Y	N	
Do you take vacations?	Y	N	
Do you smoke?	Y	N	
If so, how many packs/day?			
Have you been treated for drug/alcohol dependence?	Y	N	
Do you use recreational drugs?	Y	N	
Do you use alcoholic beverages?	Y	N	
Do you exercise?	Y	N	
How many hours per week?			
What kinds of exercise?			

Please list your interests and hobbies:

1. ____
2. ____
3. ____
4. ____
5. ____

What are the 3 major contributors to stress in your life?

1. ____
2. ____
3. ____

THANK YOU!