NAME:______________________________ DOB:____________________

Review of Symptoms: Please indicate any personal history of currently active problems below:

- ***CONSTITUTIONAL SYMPTOMS***

Good general health lately	Yes	No
Recent weight change	Yes	No
Fever/night sweats	Yes	No
Fatigue/weakness	Yes	No

- ***EYES***

Eye disease or injury	Yes	No
Glaucoma/cataracts	Yes	No

- ***EAR/NOSE/THROAT***

Problems with hearing	Yes	No
Sore throat or voice change/swollen glands	Yes	No
Chronic Sinus Problem	Yes	No
Nose bleeds/mouth sores	Yes	No

- ***CARDIOVASCULAR***

Heart trouble (murmur, rheumatic fever, valve disease, pacemaker)	Yes	No
Heart attack	Yes	No
Artificial valve	Yes	No
Chest pain or angina pectoris	Yes	No
Palpitation	Yes	No
Shortness of breath with walking or lying flat	Yes	No
Swelling of feet, ankles or hands	Yes	No
Poor circulation	Yes	No
High blood pressure	Yes	No

- ***RESPIRATORY***

Lung disease	Yes	No
Shortness of breath	Yes	No
Asthma or wheezing	Yes	No

- ***GASTROINTESTINAL***

Intestinal/stomach disease or colitis	Yes	No
Liver or gallbladder disease	Yes	No
Abdominal Pain	Yes	No
Peptic Ulcer (stomach or duodenal)	Yes	No

- ***GENITOURINARY***

Bladder problems	Yes	No
Kidney disease	Yes	No
Problems with urination	Yes	No
Kidney stones	Yes	No
Sexual difficulty	Yes	No
Male - testicle pain/lumps	Yes	No
prostate problems	Yes	No
Female - irregular periods	Yes	No
vaginal yeast infections	Yes	No
estrogen replacement	Yes	No
hysterectomy	Yes	No
PREGNANT OR NURSING	Yes	No
PLANNING A PREGNANCY	Yes	No
current form of birth control	________	
last menstrual period	________	
age at onset of menopause	________	

Please notify your doctor if you think you are pregnant or if you try to become pregnant because medications may need to be changed.

- ***MUSCULOSKELETAL***

Joint pain	Yes	No
Joint stiffness or swelling	Yes	No
Weakness of muscles or joints	Yes	No
Artificial joint	Yes	No

- ***INTEGUMENTARY (skin, breast)***

Problems with scarring or keloids	Yes	No
Ever been given Grenz ray or radiation therapy	Yes	No
Rash or itching	Yes	No
Change in skin color	Yes	No
Change in hair or nails	Yes	No
Varicose veins	Yes	No
Breast pain	Yes	No
Breast lump	Yes	No
Breast discharge	Yes	No

- ***NEUROLOGICAL DISORDER***

Frequent or recurring headaches	Yes	No
Light headed or dizzy	Yes	No
Convulsions or seizures	Yes	No
Stroke	Yes	No

- ***PSYCHIATRIC***

Nervousness	Yes	No
Depression	Yes	No
Other	Yes	No

- ***ENDOCRINE***

Glandular or hormone problem	Yes	No
Thyroid disease	Yes	No
Diabetes (insulin or non insulin - **circle one**)	Yes	No

- ***HEMATOLOGIC/LYMPHATIC***

Taking any blood thinners now	Yes	No
Slow to heal after cuts	Yes	No
Bleeding or bruising tendency	Yes	No
Anemia	Yes	No
Phlebitis	Yes	No
Past transfusion	Yes	No
Blood or lymph gland disorder	Yes	No
Cancer or leukemia	Yes	No

- ***ALLERGIC/IMMUNOLOGIC/INFECTIOUS***

History of venereal disease (STD)	Yes	No
History of HIV infection / AIDS	Yes	No
History of hepatitis	Yes	No
History of frequent infections	Yes	No

If Yes, where?__________________________

History of skin reaction or other adverse reaction to:

Local anesthesia	Yes	No
Latex rubber	Yes	No

Known food allergies:______________________________

Environmental allergies:____________________________

Any other health problem ___________________________

____

Signature: ______________________________________ Date:__________________

Reviewed by:____________________________________ Date:__________________