Chiropractic Associates, Inc.

REVIEW OF SYSTEMS Name: Date:

Do you have or have you had any trouble with any of the following:

Cardiovascular:

	Present	Past	No
Poor Circulation	❍	❍	❍
High Blood Pressure	❍	❍	❍
Low Blood Pressure	❍	❍	❍
Aortic Aneurism	❍	❍	❍
Heart Disease	❍	❍	❍
Vascular Disease	❍	❍	❍
Heart Attack	❍	❍	❍
Chest Pain	❍	❍	❍
High Cholesterol	❍	❍	❍
Pacemaker	❍	❍	❍
Jaw Pain	❍	❍	❍
Irregular Heartbeat	❍	❍	❍
Swelling of Legs	❍	❍	❍
Angina	❍	❍	❍
Congestive Heart Failure	❍	❍	❍
Heart Murmur	❍	❍	❍

Genitourinary: No ☐

	Present	Past	No
Kidney Disease	❍	❍	❍
Lower Side Pain	❍	❍	❍
Burning Urination	❍	❍	❍
Frequent Urination	❍	❍	❍
Blood in Urine	❍	❍	❍
Kidney Stone	❍	❍	❍
Cancer-Cervical/ Uterine/Ovarian	❍	❍	❍
Cancer-Prostate	❍	❍	❍

Hematologic/Lymphatic: No ☐

	Present	Past	No
Hepatitis	❍	❍	❍
Blood Clots	❍	❍	❍
Cancer	❍	❍	❍
Easy Bruising	❍	❍	❍
Easy Bleeding	❍	❍	❍
Fevers/Chills/Sweats	❍	❍	❍
Anemia	❍	❍	❍
Bleeding Disorder	❍	❍	❍
Leukemia	❍	❍	❍
Sickle Cell Disease	❍	❍	❍

Respiratory: No ☐

	Present	Past	No
Asthma	❍	❍	❍
Tuberculosis	❍	❍	❍
Shortness of Breath	❍	❍	❍
Emphysema	❍	❍	❍
Cold/Flu	❍	❍	❍
Cough/Wheezing	❍	❍	❍
Lung Cancer	❍	❍	❍
Sarcoidosis	❍	❍	❍

Ears/Nose/Throat: No ☐

	Present	Past	No
Dizziness	❍	❍	❍
Hearing Loss	❍	❍	❍
Sinus Infection	❍	❍	❍
Nosebleed	❍	❍	❍
Sore Throat	❍	❍	❍
Difficulty Swallowing	❍	❍	❍
Bleeding Gums	❍	❍	❍
Jaw Pain	❍	❍	❍
Tinnitus	❍	❍	❍
Hearing Problems	❍	❍	❍
Jaw Clicking/Popping	❍	❍	❍

Eyes: No ☐

	Present	Past	No
Glaucoma	❍	❍	❍
Double Vision	❍	❍	❍
Blurred Vision	❍	❍	❍
Cataracts	❍	❍	❍
Lazy Eye/Muscle Problems	❍	❍	❍
Retinal Problems	❍	❍	❍

Integumentary: No ☐

	Present	Past	No
Skin Lesions	❍	❍	❍
Skin Ulcers	❍	❍	❍
Skin Disease	❍	❍	❍
Ecsema	❍	❍	❍
Psoriasis	❍	❍	❍
Rashes	❍	❍	❍

Allergic/Immunologic: No ☐

	Present	Past	No
Hives	❍	❍	❍
Immune Disorder	❍	❍	❍
HIV/AIDS	❍	❍	❍
Allergy Shots	❍	❍	❍
Cortisone Use	❍	❍	❍

Gastrointestinal: No ☐

	Present	Past	No
Gallbladder Problems	❍	❍	❍
Bowel Problems	❍	❍	❍
Constipation	❍	❍	❍
Liver Problems	❍	❍	❍
Ulcers	❍	❍	❍
Diarrhea	❍	❍	❍
Nausea/Vomiting	❍	❍	❍
Bloody Stools	❍	❍	❍
Poor Appetite	❍	❍	❍
Cancer-Liver/Colon/Stomach	❍	❍	❍
Hiatal Hernia	❍	❍	❍
Jaundice/Hepatitis	❍	❍	❍

Musculoskeletal: No ☐

	Present	Past	No
Gout	❍	❍	❍
Degenerative Arthritis	❍	❍	❍
Rheumatoid Arthritis	❍	❍	❍
Joint Stiffness	❍	❍	❍
Muscle Weakness	❍	❍	❍
Osteoporosis	❍	❍	❍
Broken Bones	❍	❍	❍
Joints Replaced	❍	❍	❍
Cancer-Bone/Muscle	❍	❍	❍
Lupus	❍	❍	❍

Please answer <u>every</u> question, as we are trying to comply with government mandated electronic health records

REVIEW OF SYSTEMS

Do you have or have you had any trouble with any of the following:

Endocrine:	Present	Past	No ☐
Thyroid Disease	❍	❍	❍
Diabetes	❍	❍	❍
Hair Loss	❍	❍	❍
Menopause	❍	❍	❍
Menstrual Problems	❍	❍	❍
Adrenal Disease	❍	❍	❍
Cancer-Pancreas/Adrenal Glands	❍	❍	❍
Cancer-Thyroid	❍	❍	❍
Thyroid Problems	❍	❍	❍

Psychiatric:	Present	Past	No ☐
Depression	❍	❍	❍
Anxiety Disorder	❍	❍	❍
Unusual Stress	❍	❍	❍

Constitutional:	Present	Past	No ☐
Weight Loss/Gain	❍	❍	❍
Energy Level Problems	❍	❍	❍
Difficulty Sleeping	❍	❍	❍

Neurological:	Present	Past	No ☐
Babinski	❍	❍	❍
Stroke	❍	❍	❍
Seizures	❍	❍	❍
Head Injury	❍	❍	❍
Brain Aneurysm	❍	❍	❍
Numbness	❍	❍	❍
Severe Headaches	❍	❍	❍
Pinched Nerves	❍	❍	❍
Parkinson's Disease	❍	❍	❍
Carpal Tunnel	❍	❍	❍
Spinning/Balance	❍	❍	❍
Alzheimer's	❍	❍	❍
Cancer-Brain/Spinal Cord	❍	❍	❍
Migraine Headaches	❍	❍	❍
Vertebrae/Disc	❍	❍	❍
Multiple Sclerosis	❍	❍	❍
Fainting/Dizziness	❍	❍	❍
Tingling	❍	❍	❍

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Physician Review:
Signature
Date
Signature
Date
Signature
Date