|  |
| --- |
| Dr Saadia Mahmood ND |

**Naturopathic Adult Intake Form**

*The following information is confidential and will only be released with your authorization. This completed form is*

*required prior to your first appointment.*

General Information

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Age: \_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex (circle): M F

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Province: \_\_\_\_\_\_\_\_\_\_\_\_ Postal Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone #: Home: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact: Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you first hear about Saadia, ND? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Family Medical Doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other Health Care Providers You Are Seeing:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Speciality: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Speciality: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Health Goals**

Please list your health concerns in order of importance to you.

|  |  |  |
| --- | --- | --- |
| Health Concern | Onset | Previous Diagnosis Made? If so, what and by whom? |
| 1. |  |  |
| 2. |  |  |
| 3. |  |  |
| 4. |  |  |
| 5. |  |  |

What are your short term health goals? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What are your long term health goals? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical History**

How would you describe your general state of health? Excellent Good Fair Poor

If you are female, are you currently pregnant? Y N Due Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you are female, are you currently lactating? Y N

Do you have any allergies or sensitivities (medications, environmental, food, etc.)?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list all CURRENT medications and natural health products (prescription, over the counter, vitamins, herbs, homeopathics, etc.)

|  |  |  |  |
| --- | --- | --- | --- |
| Medication/Supplement | Dose | Treatment for: | Start Date |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

Do you receive regular screening tests completed by another doctor? Y N

If so, what? (PAP, DRE, blood tests, etc.) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When was the last time you had blood work completed? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How many times in the past 5 years have you been treated with antibiotics? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list PAST prescription medications and natural health products.

|  |  |  |  |
| --- | --- | --- | --- |
| Past Medication/Supplement | Treatment for: | Start Date | End Date |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

Have you experienced any serious conditions, illnesses, injuries, surgeries, or hospitalizations? Include approximate dates.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please check off which immunizations you have had.

□ DPT (diphtheria, pertussis, tetanus) □ Hepatitis A □ Tetanus booster; when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Haemophilus influenza B □ Hepatitis B □ Other ­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ MMR (measles, mumps, rubella) □ Polio

□ Chicken pox □ Flu shot

Did any immunizations cause complications? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family history**

Please specify the health history of the following family members

|  |  |  |  |
| --- | --- | --- | --- |
| Member | Age, if living | Age at death | Ailment(s) |
| Mother |  |  |  |
| Father |  |  |  |
| Sibling M F |  |  |  |
| Sibling M F |  |  |  |
| Maternal Grandmother |  |  |  |
| Maternal Grandfather |  |  |  |
| Maternal Aunts/Uncles |  |  |  |
| Paternal Grandmother |  |  |  |
| Paternal Grandfather |  |  |  |
| Paternal Aunts/Uncles |  |  |  |

**Personal/Psychological History**

Height: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Current Weight: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Weight Goal: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you **□** gained / **□** lost any weight recently? If so, how much: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sexual Preference: **□** Heterosexual  **□** Bisexual **□** Homosexual **□** Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital Status: **□** Married **□** Partnership **□** Separated **□** Divorced **□** Widowed **□** Single

Live with: **□** Spouse **□** Partner **□** Parent **□** Children **□** Friends **□** Alone **□** Other: ­\_\_\_\_\_\_\_\_\_\_\_\_

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Do you enjoy your work? Y N

Average number of hours you work in a week: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Religious or spiritual beliefs: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Interests/Hobbies: \_\_\_­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have pets? Y N If so, what kind? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Alcohol – How much per day or week \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Caffeine – Form and how much per day or week \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Recreational drugs – What kind and how often \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Tobacco – Form and how much per day or week \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you smoked in the past? Y N If so, how long and how much? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Environment**

Are you exposed to second hand smoke on a regular basis? Y N

Are you regularly exposed to solvents, heavy metals, fumes, pesticides/herbicides, or other toxic materials? Y N Please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How would you describe the emotional climate of your home? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How stressful is your work or other aspects of your life? (Please circle one)

(Least stressful) 1 2 3 4 5 6 7 8 9 10 (Most stressful)

**Diet**

Describe a typical day’s diet:

|  |  |
| --- | --- |
| Meal | Description |
| Breakfast |  |
| Lunch |  |
| Dinner |  |
| Snacks |  |
| Beverages (and total quantity) |  |

Do you have any food allergies or intolerances? Please list

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any dietary restrictions (religious, vegetarian, vegan, etc.)?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Physical Activity**

Do you regularly exercise? Y N What do you do for exercise; how much; how often?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Sleep**

Average number of hours of sleep per night? \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Bedtime: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Wake time: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you wake refreshed? Y N Do you fall asleep easily? Y N

Do you wake up during the night? Y N Do you fall back asleep easily? Y N

**Summary**

Do you have any preference for the type of naturopathic treatment used?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are there treatments that you are presently aware of that you would rather not have?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is there anything else that you feel is important that has not been covered?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Thank you for taking the time to complete this extensive intake form. Please bring this completed form with you to your first appointment.*

**INFORMED CONSENT**

*Please note that this form must be signed prior to your first appointment.*

Naturopathic medicine is the treatment and prevention of diseases by natural means. Naturopathic Doctors assess the whole person, taking into consideration physical, mental, emotional and spiritual aspects of the individual. Gentle, non-invasive techniques are generally used in order to stimulate the body’s inherent healing capacity. Your Naturopathic Doctor will take a thorough case history and perform a complaint oriented physical examination.

It is very important that you inform your Naturopathic Doctor immediately of any disease process from which you are suffering and any medications/over the counter drugs that you are currently taking. Please advise your Naturopathic Doctor immediately if you are pregnant, suspect you are pregnant or if you are breast-feeding.

As a patient, you will receive information about your diagnosis and/or treatment, alternative courses of action, the material effects, costs, expected benefits, risks, side effects and in each case the consequences of not having the diagnosis and/or treatment acted upon.

The staff is trained to handle emergencies should the need arise. There is some slight health risks associated with treatment by naturopathic medicine. These include but are not limited to:

* Homeopathic remedies may occasionally result in the aggravation of pre-existing symptoms. When this occurs the duration is usually short.
* Some patients experience allergic reactions to certain supplements and herbs.
* Pain, bruising or injury from venipuncture or acupuncture.
* Fainting or puncturing of an organ with acupuncture needles

I understand:

That my Naturopathic doctor will explain to me the exact nature of any treatment provided and will answer any questions I may have. I am free to withdraw my consent and to discontinue treatment at any time.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Print name Date

**FEES AND PAYMENT**

As the patient, you are responsible for the total charges incurred (visit fees plus any supplements or medicinal substances) for each visit. Payment is due at the time of service. If you have extended benefit coverage for Naturopathic Medicine, you are responsible for billing your own insurance company. Most insurance companies do not cover the supplements that we prescribe and dispense.

I understand that the Naturopathic Doctor will answer any questions that I have to the best of her ability. I understand that the results are not guaranteed. I do not expect the doctor to be able to anticipate and explain all risks and complications. I voluntarily consent to the diagnostic and therapeutic procedures in which Naturopathic Doctors are trained to utilize, except for (please list any exceptions):

­­­­­­­ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |
| --- | --- |
| Appointment | Fee |
| Initial | $150 |
| Follow up | $75 |

I understand that I may purchase any recommended medicines or supplements from any pharmacy/retail store of my choice. I understand the fee schedule as stated:

\_\_\_\_\_\_\_

**INITIAL**

INITIAL

**PATIENT CONSENT FORM FOR COLLECTION, USE AND DISCLOSURE OF PERSONAL INFORMATION**

Privacy and protecting your personal information is an important part of the Clinic. All staff members who come in contact with your personal information are aware of the sensitive nature of the information that you have disclosed to us. They are trained in the appropriate use and protection of your information.

Our privacy policy outlines what the clinic is doing to ensure that:

* Only necessary information is collected about you;
* We only share your information with your consent;
* Storage, retention and destruction of your personal information complies with existing legislation, and privacy protection protocols;
* Our privacy protocols comply with privacy legislation and standards of the naturopathic professions regulatory body.

HOW OUR CLINIC COLLECTS, USES AND DISCLOSES PATIENTS’ PERSONAL INFORMATION

We are committed to collecting, using and disclosing your information responsibility and do so for the following purposes:

* + To assess your health concerns, provide health care and advise you of treatment options
  + To establish and maintain contact with you
  + To remind you of upcoming appointments
  + To allow us to efficiently follow-up for treatment
  + To complete claims for insurance purposes
  + To invoice for goods and services and process credit card payments
  + To collect unpaid accounts and follow up on billing as required
  + To comply with all regulatory and legal requirements including court orders, statutory requirements to advise authorities of child abuse, reportable diseases and individuals who may be an imminent threat to harm themselves or others

PATIENT CONSENT

I have reviewed the above information that explains how the clinic will use my personal information, and the steps that the clinic is taking to protect my information. I agree that the clinic can collect, use, and disclose personal information about as set out above.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Print name Date

Y = A condition you have CURRENTLY

N = A condition you have NEVER had

P = A condition you have had in the PAST

REVIEW OF SYSTEMS

**Skin**

|  |  |  |  |
| --- | --- | --- | --- |
| Eczema, hives? | Y N P | Lumps? | Y N P |
| Acne, boils? | Y N P | Hair loss? | Y N P |
| Itching? | Y N P | Dryness? | Y N P |
| Colour change? | Y N P | Night sweats? | Y N P |
| Temperature change? | Y N P | Change in mole? | Y N P |
| Nail changes? | Y N P | Rashes? | Y N P |

**Head and Neck**

|  |  |  |  |
| --- | --- | --- | --- |
| Headaches? | Y N P | Head injury? | Y N P |
| Migraines? | Y N P | Dizziness? | Y N P |
| Goiter? | Y N P | Swollen glands? | Y N P |
| Pain or stiffness? | Y N P | Lump? | Y N P |

**Eyes**

|  |  |  |  |
| --- | --- | --- | --- |
| Glasses/contacts? | Y N P | Glaucoma? | Y N P |
| Eye pain? | Y N P | Cataracts? | Y N P |
| Tearing or dryness? | Y N P | Sensitive to the sun? | Y N P |
| Double vision/blurred vision? | Y N P | Itching/redness? | Y N P |

**Ear, Nose, and Throat**

|  |  |  |  |
| --- | --- | --- | --- |
| Impaired hearing? | Y N P | Ringing? | Y N P |
| Earaches? | Y N P | Vertigo? | Y N P |
| Discharge from ears? | Y N P | Frequent ear infections? | Y N P |
| Sinus problems? | Y N P | Nose bleeds? | Y N P |
| Frequent colds? | Y N P | Stuffiness? | Y N P |
| Frequent sore throats? | Y N P | Seasonal allergies? | Y N P |
| Teeth grinding? | Y N P | Loss of smell or taste? | Y N P |
| Gum problems? | Y N P | Frequent canker sores? | Y N P |
| Amalgam fillings? | Y N P | Hoarseness? | Y N P |

**Respiratory**

|  |  |  |  |
| --- | --- | --- | --- |
| Cough? | Y N P | Wheezing? | Y N P |
| Spitting up blood? Anything else? | Y N P | Asthma? | Y N P |
| Pneumonia? | Y N P | Bronchitis? | Y N P |
| Emphysema? | Y N P | Difficulty breathing? | Y N P |
| Tuberculosis? | Y N P | Shortness of breath? | Y N P |

**Gastrointestinal**

|  |  |  |  |
| --- | --- | --- | --- |
| Trouble swallowing? | Y N P | Change in thirst? | Y N P |
| Nausea? | Y N P | Change in appetite? | Y N P |
| Vomiting? | Y N P | Heartburn/indigestion? | Y N P |
| Vomiting blood? | Y N P | Constipation? | Y N P |
| Blood in stool? | Y N P | Diarrhea? | Y N P |
| Abdominal pain or cramps? | Y N P | Worms/parasites? | Y N P |
| Belching or passing gas? | Y N P | Gall bladder disease/stones? | Y N P |
| Black, tarry stools? | Y N P | Ulcer? | Y N P |
| Jaundice? (yellow skin) | Y N P | Hemorrhoids/fissures? | Y N P |
| Liver disease? | Y N P | Hernia? | Y N P |
| Bowel movements – how often? |  | Change in bowel movements? | Y N P |

**Cardiovascular**

|  |  |  |  |
| --- | --- | --- | --- |
| High blood pressure? | Y N P | Angina? | Y N P |
| Low blood pressure? | Y N P | Murmurs? | Y N P |
| Fainting? | Y N P | Blood clots? | Y N P |
| Past ECG? (echocardiogram) | Y N P | Palpitations/fluttering? | Y N P |
| Rheumatic fever? | Y N P | Chest pain? | Y N P |
| Swelling of ankles? | Y N P | Heart disease | Y N P |

**Urinary**

|  |  |  |  |
| --- | --- | --- | --- |
| Pain on urination? | Y N P | Frequent infections? | Y N P |
| Increased frequency? | Y N P | Inability to hold urine? | Y N P |
| Urination at night? | Y N P | Kidney stones? | Y N P |
| Urgency or hesitancy? | Y N P | Blood in urine? | Y N P |

**Musculoskeletal**

|  |  |  |  |
| --- | --- | --- | --- |
| Joint pain or stiffness? | Y N P | Weakness? | Y N P |
| Broken bones? | Y N P | Sciatica? | Y N P |
| Muscle spasms or cramps? | Y N P | Backache? | Y N P |
| Joint swelling? | Y N P | Neck pain/stiffness? | Y N P |

**Mental/Emotional**

|  |  |  |  |
| --- | --- | --- | --- |
| Treated for emotional issues? | Y N P | Memory problems? | Y N P |
| Mood swings? | Y N P | Anxiety or nervousness? | Y N P |
| Poor concentration? | Y N P | Depression? | Y N P |
| Tension and/or stress? | Y N P | Considered/attempted suicide? | Y N P |
| Phobias? | Y N P | Seasonal depression? | Y N P |

**Male Reproductive**

|  |  |  |  |
| --- | --- | --- | --- |
| Hernias? | Y N P | Prostate enlargement or disease? | Y N P |
| Testicular pain or masses? | Y N P | Discharge or sores? | Y N P |
| Are you sexually active? | Y N P | Chlamydia?  Gonorrhea? | Y N P |
| Impotence? | Y N P | Herpes?  Syphilis? | Y N P |
| Premature ejaculation? | Y N P | Genital warts? | Y N P |
| Do you use birth control?  What type? | Y N P | Other venereal disease? | Y N P |

**Female Reproductive**

|  |  |  |  |
| --- | --- | --- | --- |
| Age at first menses? |  | Difficulty conceiving? | Y N P |
| Age at last menses? (menopause) |  | Cervical dysplasia? | Y N P |
| Typical duration of bleed? |  | Pain during intercourse? | Y N P |
| Typical length of cycle? |  | Number of pregnancies? |  |
| Are cycles regular? | Y N P | Number of live births? |  |
| PMS? | Y N P | Number of miscarriages? |  |
| Painful menses? | Y N P | Number of abortions? |  |
| Heavy or excessive flow? | Y N P | Menopausal symptoms? | Y N P |
| Bleeding between periods? | Y N P | Chlamydia?  Gonorrhea? | Y N P |
| Clotting during menses? | Y N P | Herpes?  Syphilis? | Y N P |
| Are you sexually active? Type of birth control used? | Y N P | Genital warts? | Y N P |
| Last menstrual period? |  | Other venereal disease? | Y N P |
| Date of last PAP? |  | Unusual vaginal discharge? | Y N P |
| Abnormal PAP? | Y N P | Do you do breast self exams? | Y N P |
| Endometrioses? | Y N P | Breast pain or tenderness? | Y N P |
| Ovarian cysts? | Y N P | Breast lumps? | Y N P |
| Have you had a mammogram? | Y N P | Nipple discharge? | Y N P |

**Endocrine**

|  |  |  |  |
| --- | --- | --- | --- |
| Fatigue? | Y N P | Heat or cold intolerance? | Y N P |
| Excessive thirst? | Y N P | Hypoglycemia? | Y N P |
| Excessive hunger? | Y N P | Excessive sweating? | Y N P |
| Excessive urination? | Y N P | Hormone therapy? | Y N P |

**Peripheral Vascular**

|  |  |  |  |
| --- | --- | --- | --- |
| Easy bleeding or bruising? | Y N P | Anemia? | Y N P |
| Deep leg pain? | Y N P | Cold hands/feet/other? | Y N P |
| Varicose veins? | Y N P | Extremity swelling? | Y N P |
| Extremity numbness | Y N P | Extremity ulcers? | Y N P |

**Neurological**

|  |  |  |  |
| --- | --- | --- | --- |
| Seizures/convulsions? | Y N P | Numbness or tingling? | Y N P |
| Muscle weakness? | Y N P | Speech problems? | Y N P |
| Vertigo? | Y N P | Loss of balance? | Y N P |
| Paralysis? | Y N P | Involuntary movement? | Y N P |
| Fainting? | Y N P | Loss of memory? | Y N P |

**Immune**

|  |  |  |  |
| --- | --- | --- | --- |
| Chronically swollen glands? | Y N P | Chronic infections? | Y N P |
| Frequent cold/flu? | Y N P | Slow wound healing? | Y N P |