Guest Chiropractic Center
9438 Asheville Hwy
Inman SC 29349

Review of Systems

Patient Name: _____ **Date:** _____

Please check any of the following that apply to you:

√ General information
___ Recent weight change
___ Weakness / Fatigue
___ Fever
___ Fainting spells
___ Nausea
___ Vomiting
___ Nervousness
___ Anxiousness
___ Irritability
___ Sleeping Disorders
___ Depression
___ Cancer (If yes type(s)
_____
_____
___ Implants (If yes, where?)
_____
_____

√ Neuro-musculo-skeletal
___ Neck pain
___ Neck stiffness
___ Shoulder pain
___ Arm pain
___ Wrist / Hand pain
___ Numbness Arms or Hand
___ Upper back pain
___ Lower back pain
___ Hip pain
___ Leg pain
___ Ankle / Foot Pain
___ Numbness Legs or Feet
___ Joint Swelling
___ Tension
___ Loss of balance

√ Head
___ Headaches
___ Concussion
___ Dizziness
___ Memory Problems
___ Seizures / Convulsions

√ Eyes/Ears/Nose/Throat
___ Eyes sensitive to light
___ Wear glasses / Contacts
___ Blurred / Double vision
___ Loss of vision

√ EENT continued
___ Loss of hearing
___ Ringing in ears
___ Ear infections
___ Vertigo
___ Discharge from ears
___ Sinus problems
___ Nosebleeds
___ Loss of smell
___ Nasal discharge
___ Tooth pain
___ Mouth / Tongue sores
___ Frequent sore throats
___ Difficulty swallowing
___ Thyroid problems
___ Jaw / TMJ pain

√ Respiratory (lung)
___ Difficulty breathing
___ Chronic cough
___ Asthma
___ Bronchitis
___ Emphysema
___ Tuberculosis / Pneumonia
___ Date of last chest x-ray

√ Cardiovascular (heart)
___ Chest pain
___ Shortness of breath
___ Palpitations
___ Night Sweats
___ Cold hands and feet
___ High / Low blood pressure
___ Heart Murmur
___ EKG / ECG history

√ Gastrointestinal (stomach)
___ Loss of appetite
___ Indigestion
___ Constipation
___ Diarrhea
___ Bloody stool
___ Abdominal pain
___ Excessive gas
___ Loss of Bowel / Bladder control
___ Liver problems

√ Genito-Urinary
Female:
___ Pelvic Inflammatory Disease

√ GU female continued
___ Urinary tract infections
___ Benign tumors
___ Blood in Urine
___ Painful urination
___ Vaginal discharge
___ Currently pregnant
___ Use of birth control pills
___ Date of last menstrual period
_____
___ Onset of menopause

Dates of the following exams;
Pelvic _____
Pap Smear_____
Breast _____
___ Sexually transmitted diseases
Type: _____
_____

√ Genito-Urinary
Male:
___ Prostate problems
___ Hernia
___ Penile discharge
___ Blood in urine
___ Painful / Frequent urination
___ Testicular pain

Dates of the following exams;
Prostate _____
PSA _____
Sexually transmitted diseases
Type: _____
_____

√ Endocrine
___ Cold or Heat intolerance
___ Excessive sweating
___ Excessive thirst or hunger
___ Diabetes
___ Insulin dependent Y / N
___ Kidney Problems

√ Social History
___ Tobacco use- type _____
___ Alcohol use _____x / _____
___ Recreational drugs
___ Sexual protection (if active)

Patient Signature _____ **Date** _____

Review of Systems Form © Guest Chiropractic Center 10/16/2006