DAWDY NATUROPATHIC CLINIC
RESTORE REPLENISH REJUVENATE
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REVIEW OF SYSTEMS

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613-574-0069

NAME:___________________________ DATE:________________

Y A condition you have **NOW**
P A condition you have had in the **PAST**
N A condition you have **NEVER** had

Responses and Comments:

1)

GENERAL				
Weight				
Maximum weight				
When?				
Height				
Fatigue/Weakness (circle one)	**Y**	**P**	**N**	
Fevers/Chills (circle one)	**Y**	**P**	**N**	

2)

SKIN				
Rashes	**Y**	**P**	**N**	
Eczema, hives (circle one)	**Y**	**P**	**N**	
Acne, boils	**Y**	**P**	**N**	
Itching	**Y**	**P**	**N**	
Colour change	**Y**	**P**	**N**	
Lumps	**Y**	**P**	**N**	
Night sweats	**Y**	**P**	**N**	
Dryness/Moistness (circle one)	**Y**	**P**	**N**	
Temperature	**Y**	**P**	**N**	
Nail changes	**Y**	**P**	**N**	
Change in mole	**Y**	**P**	**N**	
Skin cancer	**Y**	**P**	**N**	
Pale/blue lips	**Y**	**P**	**N**	
Pale/blue nail beds	**Y**	**P**	**N**	

3)

HEAD				
Headache	**Y**	**P**	**N**	
Head injury	**Y**	**P**	**N**	
Dizziness	**Y**	**P**	**N**	

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4)

EYES				
Impaired vision	Y	P	N	
Glasses/contacts	Y	P	N	
Eye pain	Y	P	N	
Tearing or dryness	Y	P	N	
Double vision	Y	P	N	
Glaucoma	Y	P	N	
Cataracts	Y	P	N	
Blurring	Y	P	N	
Bothered by sun	Y	P	N	
Itching	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	
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	

7)

MOUTH and THROAT				
Frequent sore throat	Y	P	N	
Sore tongue/mouth	Y	P	N	
Gum problems	Y	P	N	
Hoarseness	Y	P	N	
Dental cavities	Y	P	N	
Loss of taste	Y	P	N	

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8)

NECK				
Lumps	**Y**	**P**	**N**	
Swollen glands	**Y**	**P**	**N**	
Goiter	**Y**	**P**	**N**	
Pain or stiffness of the neck area	**Y**	**P**	**N**	

9)

RESPIRATORY				
Cough	**Y**	**P**	**N**	
Coughing up phlegm	**Y**	**P**	**N**	
Spitting up blood	**Y**	**P**	**N**	
wheezing	**Y**	**P**	**N**	
Asthma	**Y**	**P**	**N**	
Bronchitis	**Y**	**P**	**N**	
Pneumonia	**Y**	**P**	**N**	
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**	
Shortness of breath lying down	**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**	
Past ECG	**Y**	**P**	**N**	
Other heart tests	**Y**	**P**	**N**	

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11)

BREASTS				
Do you do self exams?	Y	P	N	
Lumps	Y	P	N	
Pain (or tenderness)	Y	P	N	
Nipple discharge	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?	Y	P	N	
Is this a change?	Y	P	N	
Blood in stool	Y	P	N	
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	
Hemorrhoids	Y	P	N	
Black, tarry stool	Y	P	N	
Abdominal pain	Y	P	N	
Food allergy	Y	P	N	
Hernias	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 infections	Y	P	N	
Kidney stones	Y	P	N	
Blood in urine	Y	P	N	
Urgency	Y	P	N	
Hesitancy	Y	P	N	

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14)

MALE REPRODUCTIVE				
Hernias	**Y**	**P**	**N**	
Testicular masses	**Y**	**P**	**N**	
Testicular pain	**Y**	**P**	**N**	
Are you sexually active?	**Y**	**P**	**N**	
Sexual difficulties	**Y**	**P**	**N**	
Sexually transmitted infection/disease	**Y**	**P**	**N**	
Discharge or sores	**Y**	**P**	**N**	
Sexual preference: Heterosexual	**Y**	**P**	**N**	
Bisexual	**Y**	**P**	**N**	
Homosexual	**Y**	**P**	**N**	

15)

FEMALE REPRODUCTIVE				
Age menses began	**Y**	**P**	**N**	
Average number of days	**Y**	**P**	**N**	
Length of cycle	**Y**	**P**	**N**	
Bleeding between periods	**Y**	**P**	**N**	
Are cycles regular?	**Y**	**P**	**N**	
Pain during intercourse	**Y**	**P**	**N**	
Painful menses	**Y**	**P**	**N**	
Excessive flow	**Y**	**P**	**N**	
PMS	**Y**	**P**	**N**	
Birth control?	**Y**	**P**	**N**	
What type?	**Y**	**P**	**N**	
Number of pregnancies	**Y**	**P**	**N**	
Number of live births	**Y**	**P**	**N**	
Number of miscarriages	**Y**	**P**	**N**	
Number of abortions	**Y**	**P**	**N**	
Difficulty conceiving	**Y**	**P**	**N**	
Are you sexually active?	**Y**	**P**	**N**	
Sexual difficulties	**Y**	**P**	**N**	
Sexually transmitted infection/disease	**Y**	**P**	**N**	
Sexual preference: Heterosexual	**Y**	**P**	**N**	
Bisexual	**Y**	**P**	**N**	
Homosexual	**Y**	**P**	**N**	
Last menstrual period	**Y**	**P**	**N**	
Vaginal discharge	**Y**	**P**	**N**	
Vaginal itching	**Y**	**P**	**N**	
Last PAP (date)	**Y**	**P**	**N**	

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16)

MUSCOLOSKELETAL				
Joint pain or stiffness	**Y**	**P**	**N**	
Arthritis	**Y**	**P**	**N**	
Broken bones	**Y**	**P**	**N**	
Muscle spasms or cramps	**Y**	**P**	**N**	
Muscle 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**	
Thrombolphlebitis	**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**	
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**	

19)

ENDOCRINE				
Head of 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**	

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20)

BLOOD/LYMPHATIC				
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**	
Allergies? Please list	**Y**	**P**	**N**	

22)

EMOTIONAL				
Depression	**Y**	**P**	**N**	
Mood swings	**Y**	**P**	**N**	
Anxiety or nervousness	**Y**	**P**	**N**	
Tension	**Y**	**P**	**N**	
Phobias	**Y**	**P**	**N**	
Alcohol/drug use	**Y**	**P**	**N**	
Insomnia	**Y**	**P**	**N**	

23)

HOBBIES/HABITS				
What are your main interests and hobbies?				
Do you eat three meals daily?	**Y**	**P**	**N**	
Do you awake rested?	**Y**	**P**	**N**	
Do you sleep well?	**Y**	**P**	**N**	
Do you average 6-8 hours of sleep?	**Y**	**P**	**N**	
Do you enjoy your work/retirement?	**Y**	**P**	**N**	
Do you watch television? # hours/day?	**Y**	**P**	**N**	
Do you read?	**Y**	**P**	**N**	
Do you exercise?	**Y**	**P**	**N**	
What forms?	**Y**	**P**	**N**	
How many times/week?	**Y**	**P**	**N**	
Do you take vacations?	**Y**	**P**	**N**	
Have you been treated for drug dependence?	**Y**	**P**	**N**	
Do you use recreational drugs?	**Y**	**P**	**N**	
Do you use alcoholic beverages?	**Y**	**P**	**N**	
Have you been treated for alcoholism?	**Y**	**P**	**N**	
How often?	**Y**	**P**	**N**	