BIHC | Belleville Integrative Health Centre
WORKING TOGETHER FOR YOUR HEALTH

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Doctor of Naturopathic Medicine

Naturopathic Review of Systems

Name: ____ Date: MM/DD/YY

General	
Height	
Weight	
Weight 1 year ago	
Maximum weight	
When was this?	
Minimum weight	
When was this?	

For the following items, check the Y (yes) column if it is something you currently have, the N (no) column if you've never had it, or the P (past) column if it is something you've had in the past. Provide basic details in the space provided. If additional room is required, please use the backs of these pages.

Head and neck	Y	N	P	
Headache				
Head injury				
Dizziness				
Goitre				
Swollen glands				
Pain/stiffness				
Other:				

Eyes	Y	N	P	
Impaired vision				
Glasses/contacts				
Eye pain				
Tearing/drying				
Double vision				
Glaucoma				
Cataracts				
Blurring				
Sun sensitive				
Blind spot				
Loss of vision				
Redness				
Discharge				
Other:				

Ears	Y	N	P	
Hearing loss				
Earache				
Dizziness/loss of balance				
Discharge				
Infections				

Other:				
Nose and sinuses	Y	N	P	
Frequent colds				
Nose bleeds				
Sinus congestion				
Hay fever				
Poor/loss of sense of smell				
Other:				
Mouth and throat	Y	N	P	
Frequent sore throat				
Loss of voice				
Poor/loss of sense of taste				
Cavities				
Gum problems				
Other:				
Respiratory	Y	N	P	
Cough with blood				
Wheezing				
Asthma				
Bronchitis				
Pneumonia				
Pleurisy/pleuritic				
Emphysema				
Difficulty breathing				
Shortness of breath				
At night				
Lying down				
Tuberculosis				
Last tuberculin test				
Other:				
Cardiovascular	Y	N	P	
Heart disease				
Angina				
High blood pressure				
Murmur				
Rheumatic fever				
Chest pain				
Swelling in ankles				
Palpitations/fluttering sensation				
Cyanosis (blue lips, tongue)				
ECG				
Other heart tests				
Deep leg pain				
Varicose veins				
Thrombophlebitis				
Leg cramps				
Relating to arms/legs/hands/feet:				

Blue/purple/white in color				
Numbness				
Cold				
Ulcers				
Swelling				
Other:				
Breast	Y	N	P	
Lumps				
Pain/tenderness				
Nipple discharge				
Other:				
Gastrointestinal	Y	N	P	
Trouble swallowing				
Heartburn				
Indigestion				
Change in thirst				
Change in appetite				
Nausea				
Vomiting				
Vomiting blood				
Blood in stool				
Rectal bleeding				
Hemorrhoids				
Undigested food in stool				
Jaundice (yellow skin)				
Gall stones				
Ulcer				
Constipation				
Diarrhea				
Black, tarry stool				
Abdominal pain				
Hernia				
Other:				
Urinary	Y	N	P	
Pain with urination				
Increased frequency				
Increased frequency at night				
Inability to hold urine				
Frequent infections				
Kidney stones				
Kidney infections				
Blood in urine				
Urgency				
Hesitancy				
Other:				
Male reproductive (skip if female)	Y	N	P	
Hernias				
Testicular mass				

Testicular pain				
Sexually transmitted infection				
Discharge				
Erectile dysfunction				
Other:				
Female reproductive (skip if male)	Y	N	P	
Age of first menstrual period				
Date of last menstrual period				
Average number of days				
Of menstruation				
Of cycle				
Bleeding between periods				
Irregular cycles				
Painful periods				
Excessive flow				
PMS				
Birth control				
What type				
Sexually active				
Pain with intercourse				
Difficulty conceiving				
Number of pregnancies				
Number of live births				
Vaginal itching				
Vaginal discharge				
Yeast infections				
Bacterial vaginosis				
Sexually transmitted infection				
Date of last PAP				
Other:				
Musculoskeletal	Y	N	P	
Joint pain/stiffness				
Broken bones				
Weakness				
Joint swelling				
Back pain				
Muscle cramps/spasms				
Other:				
Neurologic	Y	N	P	
Fainting				
Seizures/convulsions				
Paralysis				
Numbness/tingling sensations				
Memory problems				
Involuntary movement				
Speech problems				
Dropping objects				
Other:				

Endocrine	Y	N	P	
Heat or cold intolerance				
Thyroid problems				
Excessive thirst				
Excessive urination				
Excessive hunger				
Diabetes				
Hypoglycemia				
Hormone therapy				
Other:				

Blood/Lymph	Y	N	P	
Anemia				
Easy bleeding/bruising				
Past transfusions				
Lymph node swelling				
Other:				

Emotional	Y	N	P	
Depression				
Mood swings				
Anxiety				
Nervousness				
Phobias				
Alcohol/substance abuse				
Problems sleeping				
Other:				

Hobbies/habits	Y	N	
Do you eat regularly (several times/day)			
Do you wake up feeling rested?			
Do you enjoy your job?			
What are non-work activities that you enjoy?			