Patient Name: Patient Number (office use):_____

Review of Systems

Please check beside any current or past concerns

- ○ Neck Problems
- ○ Back Problems
- ○ Joint Problems
- ○ Scoliosis
- ○ Swollen Joints
- ○ Arthritis
- ○ Anxiety/Depression
- ○ Weakness
- ○ Headache/Migraines
- ○ Dizziness
- ○ Numbness/Tingling
- ○ High Cholesterol
- ○ High Blood Pressure
- ○ Asthma
- ○ Seasonal Allergies
- ○ Shortness of Breath
- ○ Emphysema or COPD
- ○ Abdominal Pain
- ○ Kidney Stones
- ○ Constipation
- ○ Diarrhea

Past Medical History

Illnesses

- ○ Diabetes
- ○ Cancer
- ○ Epilepsy
- ○ Multiple Sclerosis
- ○ Stroke
- ○ Heart Disease
- ○ Shingles
- ○ Other _____
- ○ None

Operations

- ○ Cardiovascular Surgery
- ○ Cancer
- ○ Other _____
- ○ None

Family History

- ○ Stroke
- ○ Cancer
- ○ Cardiovascular Disease
- ○ Diabetes
- ○ Other _____
- ○ None

Social History

Exercise

- ○ Daily
- ○ Weekly
- ○ Never/Not Much at All

Tobacco Use

- ○ None
- ○ Smoke
- ○ Smokeless

List Prescription Medications (We can happily make a copy of your list instead of writing here)

_____
_____
_____

List Vitamins and Supplements

_____
_____
_____

Is there anything else we should know?

_____
_____
_____