PATIENT NAME:_____**DOB:** _____ **DATE:**_____

Annual Review of Systems. Please answer ALL the following questions

Do you currently use tobacco/nicotine (smoking, vaping, chewing)? ☐ Yes ☐ No

If yes. Which do you currently use? _____ How often? _____

Are you a former smoker or formerly use tobacco/nicotine (smoking, vaping, chewing)? ☐ Yes ☐ No

If yes. When did you quit? _____ What did you formerly use? _____

Do you currently use marijuana (smoking, vaping, edible, oil)? ☐ Yes ☐ No

If yes. Which do you currently use? _____ How often? _____

Do you use any recreational drugs or any prescription medications that have not been prescribed to you? ☐ Yes ☐ No

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How many drinks of wine, beer or other alcoholic beverages do you have per week? ☐ None ☐1 ☐ 2-5 ☐ 6+

Do you exercise for 20 minutes, three or more days per week? ☐ Yes ☐ Sometimes ☐ Never

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Do you follow any specific diet (low sodium, low sugar)? ☐ Yes ☐ No

If so, which diet? _____

In the past 12 months have you…

Experienced seizure/convulsions, dizziness, tremors, numbness or tingling or have recent head injury?

☐ Yes ☐ No If so, what? _____

Experienced frequent or recurring headaches? ☐ Yes ☐ No

Do you have any problems with your vision or experienced an eye injury, blurred/ double vision or been diagnosed with glaucoma?

☐ Yes ☐ No If so, what?_____

PATIENT NAME:_____ **DOB:** _____ **DATE:**_____

Experienced hearing loss/ringing, earaches, chronic sinus problems, nose bleeds, mouth sores or bleeding gums, chronic sore throat, or swollen glands in your neck?

☐ Yes ☐ No If so, what? _____

Do you have any problems with your teeth or dentures? ☐ Yes ☐ No

Experienced chest pains, irregular heartbeats (palpitations), shortness of breath, swelling in the ankles/feet or been diagnosed with high blood pressure or heart disease?

☐ Yes ☐ No If so, what? _____

Do you have a chronic cough/frequently cough, wheezing or been diagnosed with Asthma or Sleep Apnea?

☐ Yes ☐ No If so, what? _____

Experienced loss of appetite, abdominal pains, rectal bleeding, changes in stool, nausea/vomiting or diagnosed with an ulcer?

☐ Yes ☐ No If so, what? _____

Experienced insomnia, depression and/or nervousness?

☐ Yes ☐ No If so, what? _____

Do you have trouble with incontinence (leaking of urine), frequent urination, or blood in urine?

☐ Yes ☐ No If so, what? _____

Experienced joint pain, difficulty walking, weakness, balance issues, muscle weakness/cramps, or recent falls?

☐ Yes ☐ No If so, what? _____

Experienced glandular/hormone changes, excessive thirst, or been diagnosed with Diabetes or a Thyroid disorder?

☐ Yes ☐ No If so, what? _____

Do you notice cuts are slow to heal or that you bruise or bleed easily or been diagnosed with Anemia, Hepatitis, or HIV?

☐ Yes ☐ No If so, please describe? _____

PATIENT NAME:_____ **DOB:** _____ **DATE:**_____

Any history of skin cancer or any new or changing skin lesions? ☐ Yes ☐ No

If yes, year of cancer diagnosis? _____ Location of new skin lesions _____

Please list any **existing or new** allergic reactions or bad reactions to any medications (antibiotics, iodine), food (gluten, shellfish), or materials (latex) and your reaction.

_____

_____

Any new family health issues within the last 12 months?

_____

Last eye exam: _____ **Last dentist appointment**: _____

New Surgeries or Procedures in the last 12 months? ☐ Yes ☐ No

If yes what type? _____

Do you see any of the following specialties?

Cardiology	☐ Yes	☐ No	If yes, who/location: _____
Endocrinology	☐ Yes	☐ No	If yes, who/location: _____
Gynecology	☐ Yes	☐ No	If yes, who/location:_____
Nephrology	☐ Yes	☐ No	If yes, who/location: _____
Neurologist	☐ Yes	☐ No	If yes, who/location: _____
Ear/Nose/Throat	☐ Yes	☐ No	If yes, who/location: _____
Eye Doctor	☐ Yes	☐ No	If yes, who/location: _____
Dermatology	☐ Yes	☐ No	If yes, who/location: _____
Oncology	☐ Yes	☐ No	If yes, who/location: _____
Hematology	☐ Yes	☐ No	If yes, who/location: _____
Gastroenterology	☐ Yes	☐ No	If yes, who/location: _____
Pain Management	☐ Yes	☐ No	If yes, who/location: _____
Pulmonology	☐ Yes	☐ No	If yes, who/location: _____
Rheumatology	☐ Yes	☐ No	If yes, who/location: _____

PATIENT NAME:_____ **DOB:** _____ **DATE:**_____

Urology ☐ Yes ☐ No If yes, who/location: _____

Naturopath ☐ Yes ☐ No If yes, who/location: _____

Please list any medications prescribed by a specialist

_____ _____

_____ _____

_____ _____

_____ _____