RICHMOND HILL NATUROPATHIC CLINIC
10168 Yonge Street Suite 102
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Phone: (905) 237-8521
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www.richmondhillclinic.com

RHNC

Review of Systems

Name: _____ Date: _____

Height _____
Weight _____
Weight one year ago_____
Maximum weight _____ When _____

GENERAL / IMMUNITY

Condition / symptom	**Now**	**Past**	**For how long**	**Extra Comments – describe your symptoms as applicable (severity, location, amount /size, colour, odour, other characteristics)**
Weight problems				
Fatigue/weakness				
Fever/chills				
Measles				
Mumps				
Chicken pox				
Mononucleosis				
Polio				
Scarlet fever				
Smallpox				
Herpes				Frequent? ¨Y / ¨N Describe_____
Shingles				
Malaria				
HIV				

SKIN

Condition / symptom	**Now**	**Past**	**For how long**	**Extra Comments – describe your symptoms as applicable (severity, location, amount /size, colour, odour, other characteristics)**
Rashes				
Eczema, hives				
Psoriasis				
Acne, boils				
Canker sores				Frequent? ¨Y / ¨N Describe_____
Itching				
Colour change				
Lumps				
Night sweats				
Dryness/moistness				
Temperature				
Nail changes				
Change in mole				
Warts				
Skin cancer				

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HEAD

Condition / symptom	Now	Past	For how long	Extra Comments – describe your symptoms as applicable (severity, location, amount /size, colour, odour, other characteristics)
Headache				
Migraine				
Head injury				Date:
Dizziness				

EYES

Condition / symptom	Now	Past	For how long	Extra Comments – describe your symptoms as applicable (severity, location, amount /size, colour, odour, other characteristics)
Impaired vision				
Glasses/contacts				
Eye pain				
Tearing or dryness				
Double vision				
Glaucoma				
Cataracts				
Blurring				
Bothered by sun				
Itching				
Redness				
Discharge				Colour: _____ Amount: _____
Blind spot				

EARS

Condition / symptom	Now	Past	For how long	Extra Comments – describe your symptoms as applicable (severity, location, amount /size, colour, odour, other characteristics)
Impaired hearing				
Hearing devices				
Earache				
Dizziness				
Discharge				Colour: _____ Amount: _____
Ear Infections				¨Frequent
Ringing in the ears				¨Right ¨Left ¨Both ¨High pitch ¨Low pitch ¨Constant

NOSE and SINUSES

Condition / symptom	Now	Past	For how long	Extra Comments – describe your symptoms as applicable (severity, location, amount /size, colour, odour, other characteristics)
Frequent colds				
Nose bleeds				Frequency and amount: _____
Stuffiness				
Hay fever				
Sinus problems				

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MOUTH and THROAT

Condition / symptom	Now	Past	For how long	Extra Comments – describe your symptoms as applicable (severity, location, amount /size, colour, odour, other characteristics)
Frequent sore throat				
Sore tongue/mouth				
Gum problems				
Hoarseness				
Dental cavities				
Loss of taste				
Strep Throat				
Tonsillitis				

NECK

Condition / symptom	Now	Past	For how long	Extra Comments – describe your symptoms as applicable (severity, location, amount /size, colour, odour, other characteristics)
Lumps				
Swollen glands				
Goiter				
Pain or stiffness				

RESPIRATORY

Condition / symptom	Now	Past	For how long	Extra Comments – describe your symptoms as applicable (severity, location, amount /size, colour, odour, other characteristics)
Cough				
Sputum				Colour: _____ Amount: _____
Spitting up blood				
Wheezing				
Asthma				
Bronchitis				
Whooping cough				
Pneumonia				
Pleurisy				
Emphysema				
Difficulty breathing				
Pain on breathing				
Shortness of breath				
Shortness of breath at night				
Shortness of breath lying down				
Tuberculosis				
Tuberculin Test				
Last Chest-ray				Date:
Lung cancer				

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CARDIOVASCULAR

Condition / symptom	Now	Past	For how long	Extra Comments – describe your symptoms as applicable (severity, location, amount /size, colour, odour, other characteristics)
Heart disease				
Angina				
High blood pressure				Last measured: _____ Date: _____
Murmurs				
Rheumatic fever				
Chest pain				
Swelling in ankles				
Palpitations, fluttering				
Cyanosis (bluish skin: lips, nails)				
Past ECG				Date: _____ Result: _____
Other heart tests				

BREASTS

Condition / symptom	Now	Past	For how long	Extra Comments – describe your symptoms as applicable (severity, location, amount /size, colour, odour, other characteristics)
Do you do self exams				
Lumps				¨Right ¨Left ¨Both
Pain (or tenderness)				¨Right ¨Left ¨Both
Nipple discharge				¨Right ¨Left ¨Both Colour: _____ Amount: _____
Breast cancer				

GASTROINTESTINAL

Condition / symptom	Now	Past	For how long	Extra Comments – describe your symptoms as applicable (severity, location, amount /size, colour, odour, other characteristics)
Trouble swallowing				
Heartburn				
Frequent burping				
Change in thirst				Please explain: _____
Change in appetite				Please explain: _____
Nausea				
Vomiting				
Vomiting blood				
Bowel movements - how often?				
Is this a change?				
Formed stool				
Loose stool				
Diarrhea				¨Sometimes ¨Often ¨Severe (describe: _____)
Constipation				¨Sometimes ¨Often ¨Severe (describe: _____)
Alternating constipation and diarrhea				
Blood in stool				Colour: _____Amount: _____ Frequency:_____

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Mucous in stool				Colour: _____Amount: _____Frequency: _____
Undigested food in stool				
Black, tarry stool				
Gray stool				
Light-coloured stool				
Strong disagreeable odour of stool				
Belching/passing gas				¨Sometimes ¨Often ¨Severe (describe: _____)
Rectal itching				
Rectal bleeding				
Straining while passing the stool				
Hemorrhoids				
Jaundice (yellow skin)				
Hepatitis				
Other liver disease				
Gall bladder disease				
Ulcer				
Indigestion				
Abdominal pain				If present describe in details: location, severity, frequency, character:_____ _____
Food allergy				
Hernias				
Parasites				

URINARY

Condition / symptom	**Now**	**Past**	**For how long**	**Extra Comments – describe your symptoms as applicable (severity, location, amount /size, colour, odour, other characteristics)**
Colour of urine				¨Dark Yellow ¨Bright Yellow ¨Cloudy ¨Pale ¨Clear
Pain on urination				
Burning sensation during/after urination				
Increased frequency				Please specify: _____
Frequency at night				Please specify: _____
Inability to hold urine				
Difficulty starting or stopping when urinating				
Frequent bladder /kidney infections				If in the past - how was it treated?
Kidney stones				
Blood in urine				Colour: _____Amount: _____ Frequency: _____
Urgency				
Hesitancy				

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MALE REPRODUCTIVE

Condition / symptom	**Now**	**Past**	**For how long**	**Extra Comments – describe your symptoms as applicable (severity, location, amount /size, colour, odour, other characteristics)**
Hernias				Location:
Testicular masses				¨Left ¨Right ¨Both
Testicular pain				
Are you sexually active?				
Sexual difficulties				Any problems with getting or maintaining an erection? _____
Venereal disease				Type:
Penile discharge				Colour: _____Amount: _____Frequency: _____
Penis sores				
Sexual orientation: Heterosexual				
Bisexual				
Homosexual				
Other_____				
Prostate Problems				How often do you get up in the night to urinate? _____
Have you had prostate exam				Date:
Fertility Problems				

FEMALE REPRODUCTIVE

Condition / symptom	**Now**	**Past**	**For how long**	**Extra Comments – describe your symptoms as applicable (severity, location, amount /size, colour, odour, other characteristics)**
Age menses began				
Average number of days (menstruation)				
Length of cycle				
Last menstrual period				Date:
What colour is the blood				
Clots in the menstrual flow				
Bleeding between periods				Does it happen every month? ¨Y / ¨N
Are cycles regular				
Painful menses				¨No ¨Light ¨Moderate ¨Severe
Excessive flow				
Scanty flow				
PMS				Please list the symptoms: _____
Pain during intercourse				
Birth control? What type				
Number of				

pregnancies				
Number of live births				
Number of miscarriages				
Number of abortions				
Difficulty conceiving				
Are you sexually active?				
Sexual difficulties				
Venereal disease				Type:
Sexual orientation: Heterosexual				
Bisexual				
Homosexual				
Other_____				
Vaginal discharge				Colour: _____Amount: _____Frequency: _____
Vaginal itching				
Vaginal burning				
Last PAP smear				Date:
Abnormal PAP smears				Date:

MUSCULOSKELETAL

Condition / symptom	**Now**	**Past**	**For how long**	**Extra Comments – describe your symptoms as applicable (severity, location, amount /size, colour, odour, other characteristics)**
Joint pain or stiffness				
Arthritis				
Broken bones				
Muscle spasms or cramps				
Weakness				
Joint swelling				
Backache				
Gout				

PERIPHERAL VASCULAR

Condition / symptom	**Now**	**Past**	**For how long**	**Extra Comments – describe your symptoms as applicable (severity, location, amount /size, colour, odour, other characteristics)**
Deep leg pain				¨Left ¨Right ¨Both
Cold hands/feet				
Varicose veins				
Thrombophlebitis				
Leg cramps				
Extremity numbness				
Extremity coldness				
Extremity swelling				
Extremity ulcers				
Hemorrhoids				

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NEUROLOGIC

Condition / symptom	**Now**	**Past**	**For how long**	**Extra Comments – describe your symptoms as applicable (severity, location, amount /size, colour, odour, other characteristics)**
Fainting				
Seizures/convulsions				
Stroke				
Paralysis				
Muscle weakness				
Numbness or tingling				Location:
Loss of memory				
Involuntary movement				Please specify: _____ _____
Loss of balance				
Speech problems				Please specify:_____ _____

ENDOCRINE

Condition / symptom	**Now**	**Past**	**For how long**	**Extra Comments – describe your symptoms as applicable (severity, location, amount /size, colour, odour, other characteristics)**
Heat or cold intolerance				
Thyroid trouble				
Excessive thirst				
Excessive hunger				
Excessive urination				
Excessive sweating				
Diabetes				
Hypoglycemia				
Hormone therapy				Type:

BLOOD/LYMPHATIC

Condition / symptom	**Now**	**Past**	**For how long**	**Extra Comments – describe your symptoms as applicable (severity, location, amount /size, colour, odour, other characteristics)**
Anemia				
Easy bleeding or bruising				
Past transfusions				
Lymph node swelling				

ALLERGIC HISTORY

Condition / symptom	**Now**	**Past**	**For how long**	**Extra Comments – describe your symptoms as applicable (severity, location, amount /size, colour, odour, other characteristics)**
Drug sensitivity				Please specify: _____
Reaction to vaccine				Type of vaccine: _____ Date: _____
Allergies? Please list				

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EMOTIONAL

Condition / symptom	**Now**	**Past**	**For how long**	**Extra Comments – describe your symptoms as applicable (severity, location, amount /size, colour, odour, other characteristics)**
Depression				
Mood swings				
Anxiety or nervousness				
Tension				
Phobias				
Alcohol/drug abuse				
Insomnia				
Child Abuse				
Physical Abuse				
Sexual Abuse				
Emotional Abuse				

Other condition not listed above _____

Are there any of these from which you feel you have been never well since? _____

_____

_____

What is your weakest organ system and why (your view):

¨Digestive

_____

¨Immune

_____

¨Respiratory

_____

¨ Cardiovascular _____

¨Reproductive _____

¨Urinary (kidney, bladder) _____

¨Nervous system _____

¨Skin _____

¨Muscular – skeletal _____

¨Vision _____

¨Hearing _____

Thank you for taking time to fill in this questionnaire. It will be a valuable resource to evaluate your current health.

For file use only