Case History

Age: ______ Height: _______ Weight: _______

Review of Systems:

□ Yes □ No Do you have skin, hair, or nail problems?____

□ Yes □ No Do you have mouth and/ or throat problems?____

□ Yes □ No Do you have nose and/ or sinus problems?____

□Yes □ No Do you have ear problems?____

□ Yes □ No Do you have eye problems?____

□Yes □ No Do you have chest or lung (breathing) problems? ____

□Yes □ No Do you smoke? Cigarettes per day: _________ How long? __________________________

□ Yes □ No Do you have heart and/ or blood vessel problems?____

□ Yes □ No Do you have blood or lymph node problems?____

□ Yes □ No Do you have digestive problems?____

□ Yes □ No Do you have genital problems? (e.g. prostate, testicular, vaginal)?___________________________

□ Yes □ No Do you have urinary (including kidney or bladder) problems?_____________________________

Females:

□Yes □ No Females: have you had menstrual problems?____

□ Yes □ No Have you ever taken birth control pills?____

□Yes □ No Do you have any breast problems?____

□ Yes □ No Do you have any nervous system diseases and/ or mental health problems?___________________

□ Yes □ No Do you have any gland and/ or hormone problems?______________________________________

□ Yes □ No Do you have allergy or immunity problems?____

□ Yes □ No Do you have any muscle, tendon, or ligament problems?__________________________________

□ Yes □ No Do you have any bone or joint diseases (ex: bone=osteoporosis, joint= arthritis?

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Additional Questions:

□ Yes □ No Do you have problems with recurring headaches?______________________________

□ Yes □ No Are you losing weight without trying?

□Yes □ No Does your pain wake you up at night?

□ Yes □ No Have you had a change in bowel or bladder habits?_____________________________

□ Yes □ No Have you had a sore that doesn't heal?______________________________________

□ Yes □ No Have you recently had any unusual bleeding or discharge?_______________________

□ Yes □ No Do you have a thickening/lump in the breast or elsewhere?_______________________

□ Yes □ No Do you have indigestion or difficulty swallowing?_______________________________

□ Yes □ No Have you had an obvious change in a wart or mole?_____________________________

□Yes □ No Do you have a nagging cough or horseness?_____________________________________