Dieringer Chiropractic Health Clinic
11141 W 191st Street
Mokena Il, 60448
(708) 478-0620, Fax (708) 479-8948

REVIEW OF SYSTEMS FORM

PATIENT'S NAME: **DATE:**

PLEASE CHECK ANY OF THE FOLLOWING THAT APPLY TO YOU:

GENERAL INFORMATION:

ANY RECENT WEIGHT GAIN/LOSS_____
WEAKNESS_____
FATIQUE_____
FEVER_____
FAINTING SPELLS_____
NAUSEA_____
VOMITING_____
BALANCE PROBLEMS_____
JAW PAIN (TMJ)_____
NECK PAIN_____
NECK STIFFNESS_____
SHOULDER PAIN____
ARM PAIN_____
WRIST/HAND PAIN_____
NUMBNESS ARMS OR HAND_____
UPPER BACK PAIN_____
LOWER BACK PAIN____
HIP PAIN_____
LEG PAIN_____
ANKLE/FOOT PAIN_____
NUMBNESS LEGS OR FEET_____
JOINT SWELLING_____
TENSION_____
NERVOUSNESS_____
ANXIETY_____
IRRITABILITY_____
SLEEPING PROBLEMS/INSOMINA_____
DEPRESSION_____
LIVER PROBLEMS_____
CANCER (IF YES INDICATE WHEN AND TYPE)_____
_____
METAL IMPLANTS (IF YES INDICATE WHEN AND WHERE)_____
_____
_____

HEAD:

HEADACHES_____
LOSS OF CONSCIOUSNESS_____
DIZZINESS_____
MEMORY PROBLEMS_____
SEIZURES/CONVULSIONS_____

EYES:

WEAR EYE GLASSES/CONTACT LENSES_____
DOUBLE VISION_____
BLURRED VISION_____
LOSS OF VISION_____
EYES SENSITIVE TO LIGHT_____

EARS:

LOSS OF HEARING_____
RINGING/BUZZING IN EARS (TINNITIS)_____
EAR INFECTIONS_____
VERTIGO (DIZZINESS)_____
ANY DISCHARGE FROM EARS_____

NOSE:

SINUS PROBLEMS_____
EPITAXIS (NOSEBLEEDS)_____
LOSS OF SMELL_____
ANY DISCHARGE FROM NOSE_____

MOUTH/THROAT:

TOOTH PAIN_____
ANY LESIONS/SORES IN MOUTH, LIPS OR GUMS_____
FREQUENT SORE THROATS_____
DIFFICULTY SWALLOWING_____
THYROID PROBLEMS_____

RESPIRATORY (LUNG PROBLEMS):

DIFFICULTY BREATHING_____
CHRONIC COUGH_____
ASTHMA_____
BRONCHITIS_____
EMPHYSEMA_____
EVER HAVE TUBERCULOSIS OR PNEUMONIA_____
DATE OF LAST CHEST RADIOGRAPH_____

CARDIOVASCULAR (HEART PROBLEMS):

CHEST PAIN_____
DIFFICULTY BREATHING (SHORTNESS OF BREATH)_____
PALPITATIONS_____
NIGHT SWEATS_____
COLD EXTREMITIES_____
HIGH BLOOD PRESSURE_____
LOW BLOOD PRESSURE_____
HEART MURMUR_____
EVER HAVE AN ECG/EKG_____

GI (GASTROINTESTINAL):

UPSET STOMACH_____
LOSS OF APPETITE_____
INDIGESTION_____
CONSTIPATION_____
DIARRHEA_____
BLOODY STOOL_____
ABDOMINAL PAIN_____
EXCESSIVE GAS_____
LOSS OF BOWEL CONTROL_____

- CONTINUED ON NEXT PAGE→

ROS FORM CONTINUED:

PATIENT'S NAME: _____

PLEASE CHECK ANY OF THE FOLLOWING THAT APPLY TO YOU:

GU (GENITALURINARY):

FEMALES:

HISTORY OF PELVIC INFLAMMATORY DISEASE_____
URINARY TRACT INFECTIONS_____
BREAST CANCER &/OR BENIGN TUMORS_____
BLOOD IN URINE_____
PAINFUL URINATION_____
VAGINAL DISCHARGE_____
PMS_____
LOSS OF BLADDER CONTROL_____
CURRENTLY PREGNANT_____
USE BIRTH CONTROL PILLS_____
DATE OF LAST MENSTRUAL PERIOD (DLMP)_____
IF INDICATED AGE OF MENOPAUSE_____
LAST PELVIC EXAM (DATE & RESULTS)_____
_____
LAST PAP SMEAR (DATE & RESULTS)_____
_____
LAST BREAST EXAM (DATE & RESULTS)_____
_____
ANY SEXUAL TRANSMITTED DISEASE (STD'S)_____
_____
_____
_____

MALES:

PROSTATE PROBLEMS_____
HERNIAS_____
PENILE DISCHARGE_____
BLOOD IN URINE_____
PAINFUL URINATION_____
FREQUENT URINATION_____
TESTICULAR PAIN_____
LOSS OF BLADDER CONTROL_____
LAST PROSTATE EXAM (DATE & RESULTS)_____
_____
LAST PSA (DATE & RESULTS)_____
_____
ANY SEXUAL TRANSMITTED DISEASES (STD'S)_____
_____
_____
_____

ENDOCRINE:

COLD OR HEAT INTOLERANCE_____
EXCESSIVE SWEATING_____
EXCESSIVE THIRST OR HUNGER_____
DIABETES (IF YES INDICATE IF INSULIN DEPENDENT)_____
_____
THYROID PROBLEMS_____
KIDNEY PROBLEMS_____

DOCTOR'S NAME: _____

MEDICATIONS: PLEASE LIST ALL MEDICATIONS CURRENTLY TAKING (DOSAGE, FREQUENCY AND REASON TAKING MEDICATIONS)

_____
_____
_____
_____
_____
_____
_____
_____
_____

SOCIAL HISTORY:

USE TOBACCO (SMOKE)-IF YES INDICATE HOW MUCH AND HOW LONG BEEN SMOKING_____
_____
_____
_____
_____
_____

USE ALCOHOL (DRINK)-IF YES INDICATE HOW OFTEN AND HOW MUCH_____
_____
_____
_____
_____

USE RECREATIONAL DRUGS-IF YES INDICATE WHAT AND HOW OFTEN_____
_____
_____
_____
_____

SEXUALLY ACTIVE-IF YES INDICATE WHAT FORM OF PROTECTION_____
_____
_____
_____
_____

PATIENT'S SIGNATURE:

X_____

DATE:

X_____