

Dieringer Chiropractic Health Clinic
19806 Wolf Road, Suite #104
Mokena Il, 60448
(708) 478-0620

REVIEW OF SYSTEMS

PATIENT'S NAME: _____ **DATE:** _____

PLEASE CHECK ANY OF THE FOLLOWING THAT APPLY TO YOU:

GENERAL INFORMATION:

- ANY RECENT WEIGHT GAIN/LOSS _____
- WEAKNESS _____
- FATIGUE _____
- FEVER _____
- FAINING 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 EYEGLASSES/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 _____

CONTINUE 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 _____

YOUR 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 _____