

Total Wellness Centre

10 Roden Place

Toronto, On M5R 1P5

www.totalwellnesscentre.ca

416 532 9094



Review of Systems

Name:

Date of birth:

Today's Date:

YOUR HEALTHCARE TEAM

Please list all healthcare practitioners who help treat you:

Name	Type of practitioner (eg. family doctor, counsellor, acupuncturist, RMT)	Phone and fax number
		Phone: Fax:
		Phone: Fax:
		Phone: Fax:

MEDICATION YOU ARE CURRENTLY TAKING

Name/ brand/ type	Dose	For what condition	Since when

PAST MEDICATION

Name/ brand/ type	Dose	For what condition	For how long?

NATURAL HEALTH PRODUCTS YOU ARE CURRENTLY TAKING

Product/ brand	Dose	Reason	Since when

MEDICAL HISTORY

Have you ever been hospitalized/ had surgery?

Date:	Reason	Problems experienced since

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For each item, please circle symptoms that you are experiencing or have experienced

SKIN, HAIR, NAILS			
Redness/ rashes/ eczema/ psoriasis/ hives/ itching		Acne/ boils/ infection/ bumps/ lumps	
Excess dryness/ excess sweating/ sensitive		Moles/ skin ulcers/ discoloration/ cancer	
Hair loss/ hair changes		Nail changes (shape, strength, thickness)	
Have you ever had a complete skin exam?		Date:	
HEAD			
Headache/ Dizziness		Head injury	Problems with jaw joint? (TMJ)
Have you ever had an MRI, CT Scan etc?		Date:	Result:
EYES			
Impaired vision/ double vision/ blurring/ floaters		Glasses/ contact lenses	
Eye pain/ itching/ discharge/ light sensitive		Excess tearing/ dryness/ redness	
Glaucoma/ cataracts			
When did you last visit your eye doctor?		Do you use eye drops, artificial tears or other eye products?	
EARS			
Earache/ Infection		Excess ear wax / Discharge	
Ringing/ Impaired hearing		Ruptured ear drum/ Ear tubes	
NOSE AND SINUSES			
Frequent colds/ stuffiness		Sinus problems/ Nose bleeds	Allergies/ hay fever
MOUTH, THROAT AND NECK			
Frequent sore throat/ hoarseness/ sore or dry tongue/ mouth		Gum problems/ bleeding	
Lumps/ swollen glands in neck		Thyroid problems/ goiter	Pain/ stiffness in neck
How often do you brush and floss?		How many dental cavities? What type of filling?	
When was your last visit to the dentist?			
RESPIRATORY			
Cough/ wheezing / sputum/ mucous/ blood		Pain/ difficulty breathing/ Shortness of breath/ apnea	
Asthma/ Bronchitis/ Pneumonia/ Emphysema/ Pleurisy (inflammation of lungs)/ Tuberculosis			
Do you / have you smoke(d)?		How long?	How many?
Tuberculin test Date:		Test result:	Date of last chest x-ray
CARDIOVASCULAR			
High blood cholesterol/ Heart disease/ High blood pressure		Angina/ chest pain	
Murmur/ irregular heart beat/ palpitations/ fluttering			
Swelling in ankles		Rheumatic fever/ Cyanosis (blueness)	
Past ECG/ Stress test/ other imaging		Date:	Result:
BREASTS			
Lumps/ skin puckering/ Pain or tenderness/ change in appearance		Nipple discharge/ changes	
Implants/ reduction/ surgery			
Have you ever breast fed? Any problems breast feeding?		Do you do self exams? Mammograms/ imaging?	
Is there is history of breast cancer in your family?			
GASTROINTESTINAL			
Heartburn/ acid reflux/ nausea/ vomiting/ blood		Excess gas/ Indigestion/ bloating/ abdominal pain	
Trouble swallowing/ Changes in appetite/ thirst		Offensive breath/ bad taste in mouth	
Ulcer/ Hernia/.Polyps		Diarrhea/ constipation/Rectal bleeding/ hemorrhoids	
Blood/ mucous/ undigested food in stool		Black tarry stool	
Gall bladder disease/ stones/ removal		Liver disease/ hepatitis	
How often are your bowel movements?		Is this a change?	
Food allergies/ sensitivities?		Please list offending foods:	

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How is your appetite? a) I'm hungry all the time and can't seem to satisfy my hunger (regular meals aren't enough) b) It seems normal to me (eat regular meals) c) I'm not often hungry and I sometimes have to force myself to eat (can easily skip meals)	
How is your thirst? a) I've noticed an increased thirst that I can't satisfy (drink a lot of fluids throughout the day) b) It seems normal to me (drink fluids throughout the day) c) I'm not usually thirsty (I forget to drink fluids)	
What food restrictions do you have?	
Do you have any food cravings? Please list the foods that you crave most:	What affects your food cravings?
How much water do you drink? (do not include caffeinated drinks or alcohol) Do you drink tea, coffee, or pop? How much? Do you drink alcohol? What kind? How much?	
Please circle the following products that you consume on a regular basis (several times per week) Salt Butter Margarine Sugar Artificial sweetener Mayonnaise Soy sauce Spice mixes Jarred or canned sauces Frozen or instant foods Snacks (chips, cookies, candy, candy bars etc)	
How many meals per week do you eat out? Meals/ week	
Have you had any gastrointestinal surgeries/ tests?	Do you take antacids/ special digestive aids?
Is there a history of colorectal cancer in you family?	
URINARY	
Pain/ pressure/ blood with urination	Frequent urinary infections
Urgency/ hesitancy	Inability to hold urine/ incontinent
Increased frequency, day or night	Kidney problems (stones, infections)
MALE REPRODUCTIVE	
Prostate problems	Testicular masses/ pain
When was last prostate exam?	Do you do testicular self-exams?
Any sexual difficulties/ erectile dysfunction	Discharge/ sores/ rash
Problems with sperm/ semen/ conceiving	
FEMALE REPRODUCTIVE	
Age of first period	Average number of days of bleeding
Length of cycle (# of days from first day of period to day before next period)	
Bleeding between periods/ Irregular cycles/ excess flow	Endometriosis/ Ovarian cysts
Vaginal itching/ redness/ yeast infections	Abnormal PAP results/ Cervical cancer
Sexual difficulties/ pain during intercourse	Hormonal birth control
Number of pregnancies	Number of miscarriages/ abortions
Number of live births	Difficulties conceiving
Menopause? at what age?	
Hot flashes/ dryness/ other problems with menopause	Hormonal therapy for menopause
PMS (circle those that apply) a) Cramps/ muscle achiness d) cravings b) water retention/ bloating e) mood changes c) tender breasts f) other d)	Vaginal discharge (circle those that apply) a) clear fluid d) greenish/yellow b) white e) grey c) thick or sticky f) strong odour (fishy)
Date of last PAP	Result

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MALE AND FEMALE SEXUAL	
Are you currently sexually active?	Do you use barrier contraception (eg condom)?
Have you ever tested positive for any sexually transmitted infection?	
MUSCULOSKELETAL	
Joint pain/ stiffness/ swelling/ Arthritis/ Back pain	Muscle weakness/ spasms/ cramps/ sciatica
Bone fractures/ nerve pain or injury	Have you ever had a bone density test?
History of joint or bone injury/ accidents	
PERIPHERAL VASCULAR	
Cold hands/ feet	Deep leg pain/ leg cramps/ Vein pain (thrombophlebitis)
Varicose veins	Extremity numbness/ swelling/ pain/ ulcers
NEUROLOGIC	
Fainting / loss of balance/ loss of memory	Numbness or tingling/ loss of control/ Paralysis
Seizures/ convulsions/ involuntary movement	Speech problems/ slurring
ENDOCRINE	
Very sensitive to heat or cold	Hypoglycemia (low blood sugar)/ Diabetes
Thyroid problems	Hormone/ steroid therapy
Excessive thirst/ hunger	Excessive urination/ sweating
BLOOD/ LYMPHATIC	
Anemia	Easy bleeding/ bruising
	Lymph node swelling
Hemophilia/ clotting problems/ Blood transfusions	
What is your blood type?	
ALLERGIES	
Any reactions to vaccines?	Drug sensitivities
Please list all allergies	
MENTAL EMOTIONAL	
Mood swings/ Sleeping difficulties/ insomnia	Depression
Anxiety Excess stress	Phobia
Have you experienced past trauma/ significant grief?	
Are you still affected by it today?	
Substance abuse?	Have you been treated for substance abuse?
Thoughts of suicides/ attempts?	
Have you ever sought help or used medication to deal with personal problems?	
SLEEP	
How many hours do you usually sleep?	How many hours of sleep do you <i>need</i> ?
If you have trouble sleeping, please circle all that apply	
a) I have problems falling asleep	
b) I have problems staying asleep. If so, what time(s) do you usually wake up? _____	
c) I take medication or other substances to help me sleep	
Do you awake well rested?	Do you take naps during the day?
Do you fall asleep during the day?	Do you talk/ walk in your sleep?
Grind teeth while sleeping	Have vivid dreams
Sleep apnea	Shift work
ENERGY	
How is your energy? (please choose one)	
a) I have plenty of energy for work and for all my daily activities	
b) I have enough energy during work, but feel tired for the rest of the day	
c) I don't have enough energy for work or any other activities	
What affects your energy level?	

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EXERCISE

How would you describe your daily activity level?

- a) very active
- b) moderately active
- c) sedentary

Do you exercise regularly?

How frequently?

What kind?

For how long?

FAMILY MEDICAL HISTORY

Has anyone in your family (siblings, parents, grandparents) had the following conditions?	✓	Which member was affected by this condition:	Age
Heart disease			
High blood pressure			
Diabetes/ blood sugar problems			
Asthma or other respiratory (lung) problems			
Allergies			
Cancer (breast, colon, lung, liver, skin, prostate etc)			
Psychiatric (depression, anxiety, addiction etc)			
Kidney problems			
Hormonal problems (thyroid, pituitary, estrogen, testosterone, adrenal (cortisol) etc)			
Congenital (birth)/ developmental problem or genetic			
Neurologic problems (eg. MS, parkinson's, Alzheimer's)			
Arthritis			
Digestive (Celiac's disease, Crohn's, Ulcerative colitis, Irritable Bowel Syndrome, Diverticulitis, Lactose intolerance, Gall stones etc)			
Other			

In case of emergency call:

Name:

Relationship:

Phone:

Do you have any life threatening allergies (ie. anaphylaxis, medication)?

Medications:

Thank-you for your co-operation and participation! I welcome any questions that you may have. We look forward to our scheduled appointment.

Yours in health,

EeVon Ling BSc. ND