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 b) water retention/ bloating c) tender breasts d)	d) cravings e) mood changes f) other
Vaginal discharge (circle those that apply) a) clear fluid b) white c) thick or sticky	d) greenish/yellow e) grey 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 *need*?	
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? For how long? What kind?

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, Alzeimer'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