ADAMGRATTON N.D.
NATUROPATHIC DOCTOR

Please complete this form as thoroughly as possible. The information provided is kept strictly confidential. This complete form is required prior to your first appointment.

REVIEW OF SYSTEMS

(Please print clearly)

For each item, please check ☑ symptoms you are currently experiencing in the "**Y**" column, and symptoms you've experienced in the past in the "**P (date)**" column, *along with when you last experienced the symptom (i.e. Aug 05, or 1998-2003)*.

Symptom	Y	P (Date)	Symptom	Y	P (Date)
SKIN					
Rashes/hives/itching			Hair changes (colour, loss)		
Acne/boils/bumps/lumps			Nail changes (strength, shape)		
Excess dryness/moistness			Temperature/night sweats		
Changes to moles			Skin ulcers/cancer		
Eczema/Psoriasis			Changes in skin colour		
HEAD					
Headache			Problems with jaw joint (TMJ)		
Head injury			Dizziness		
Migraines					
EYES					
Impaired vision/blurring			Double vision		
Floaters/blind spots			Corrective lenses		
Sensitivity to sunlight			Eye pain/itching/discharge		
Excess tearing/dryness/redness			Glaucoma		
Cataracts			Date of last visit to eye doctor		
EARS					
Ringing			Ruptured ear drum		
Impaired hearing/hearing aids			Excess ear wax/discharge		
Earache/pain/infection			Do you use Q-Tips?		
NOSE AND SINUSES					
Frequent colds			Sinus problems		
Nose bleeds			Sensitive to smells		
Allergies/Hay fever			Change in ability to taste		
MOUTH, THROAT AND NECK					
Frequent sore throat/hoarseness			Lumps/swollen glands in neck		
Sore or dry tongue/mouth			Thyroid problems		
Gum problems/bleeding			Pain/stiffness in neck		
Mercury dental fillings			Date of last visit to dentist		
RESPIRATORY					
Cough			Asthma/wheezing		
Shortness of breath at night			Sputum/mucous		
Bronchitis/Pneumonia			Spitting/Coughing up blood		
Emphysema			Pain/Difficult Breathing		
Tuberculosis					
CARDIOVASCULAR					
Heart Disease			High blood cholesterol		
Angina/Chest pain			Rheumatic fever		
High blood pressure			Murmur		
Irregular heart beat/palpitations			Cyanosis (blueness to lips/nails)		

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Symptom	Y	P (Date)	Symptom	Y	P (Date)
GASTROINTESTINAL					
Heartburn/Acid reflux			Belching/Gas		
Trouble swallowing			Bad breath/Bad taste in mouth		
Changes in appetite/thirst			Bloating/Abdominal pain		
Nausea/Vomiting			Hernia		
Blood in stool			Mucous/Undigested food in stool		
Indigestion			Diarrhea/Constipation		
Gall Bladder stones/removal			Rectal bleeding/Hemorrhoids		
Ulcer			Black tarry stool		
MUSCULOSKELETAL					
Joint pain/stiffness/arthritis			Muscle weakness/spasm/cramps		
Bone fractures			Back pain		
Sciatica			Osteoporosis		
PERIPHERAL VASCULAR					
Cold hands/feet			Painful veins (thrombophlebitis)		
Varicose veins			Deep leg pain/cramps		
Ankle/leg swelling					
NEUROLOGIC					
Fainting/Loss of consciousness			Numbness/tingling		
Seizures/convulsions			Twitching/Involuntary movement		
Speech problems/slurring			Paralysis		
Loss of memory					
ENDOCRINE					
Sensitive to heat or cold			Diabetes		
Thyroid problems			Low blood sugar (hypoglycemia)		
Excessive thirst/hunger			Hormone replacement therapy		
Steroid therapy/use			Excessive urination/sweating		
BLOOD/LYMPHATIC					
Anemia			Lymph node swelling		
Easy bleeding/bruising			Hemophilia/clotting problems		
Blood transfusions			What is your blood type?		
FEMALE REPRODUCTIVE HEALTH					
Breast lumps/skin puckering			Nipple discharge/changes		
Breast pain/tenderness			Breast implants/surgery		
Do you do self breast exams?			Family history of breast cancer?		
Age of first period			Average number of days of bleeding		
Length of menstrual cycle (# of days from first day of period to day before next period)					
Bleeding between periods			Irregular menstrual cycles		
Heavy menstrual bleeding			Ovarian cysts		
Endometriosis			Sexual difficulties		
Pain during intercourse			Yeast/Candida infections		
Vaginal itching/redness			Vaginal discharge		
Menopause			Year menopausal symptoms began		
Birth control pills			Number of pregnancies		
Number of live births			Number of miscarriages/abortions		
Date of last Pap			Results of last PAP		
PMS (Describe symptoms)					

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MALE REPRODUCTIVE HEALTH					
Testicular pain/masses			Prostate problems		
Do you do testicular self exams?			Penile discharge		
Penile ulcers/sores			Erectile dysfunction		
Sexual difficulties			Problem with sperm count/motility		
MALE AND FEMALE SEXUAL HEALTH					
Are you sexually active			Age of first sexual encounter		
Do you use barrier contraception?			Sexually transmitted infections		
Sexual preference			Are you happy with your sex life		
Symptom	**Y**	**P (Date)**	**Symptom**	**Y**	**P (Date)**
URINARY					
Pain/burning while urinating			Blood in urine		
Inability to hold urine/incontinence			Urgency/Hesitancy		
Frequent urinary tract infections			Kidney problems (stones, infection)		
MENTAL/EMOTIONAL					
Mood swings			Depression		
Anxiety			Sleeping difficulties/Insomnia		
Phobias			Excess stress		
Thoughts of suicide			Treated for substance abuse?		

If there any other health concerns/symptoms not describe in this form that you feel are important to note, or if you would like to provide more information on checked symptoms, please use the space below.

Thank you for taking the time to complete this form.

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