Name:_________________________________ File#:_____________ Date:_____________
CC:____

Pinnacle Chiropractic, PLLC

Review of Systems

Below is a list of symptoms that may seem unrelated to the purpose of the appointment. However, these questions must be answered carefully as the problems can affect the overall course of care.

General:
☐ **Patient DENIES having or have had any of the symptoms or problems listed below.**

☐ chills	☐ fatigue	☐ night sweats	☐ weight loss
☐ daytime drowsiness	☐ fever	☐ weight gain	☐ cancer

Eyes/Vision:
☐ **Patient DENIES having or have had any of the symptoms or problems listed below.**

☐ blindness	☐ change in vision	☐ field cuts	☐ photophobia
☐ blurred vision	☐ double vision	☐ glaucoma	☐ tearing
☐ cataracts	☐ eye pain	☐ itching	☐ wear glasses/contacts

Ears, Nose, and Throat:
☐ **Patient DENIES having or have had any of the symptoms or problems listed below.**

☐ bleeding	☐ear drainage	☐ hearing loss	☐ nosebleeds
☐ sore throat	☐ dentures	☐ ear pain	☐ history of head injury
☐ postnasal drip	☐ tinnitus (ringing in ears)		☐ difficulty swallowing
☐ fainting	☐ hoarseness	☐ runny nose	☐ TMJ problems
☐ discharge	☐ snoring	☐ nasal congestion	☐ loss of sense of smell
☐ sinus infections	☐ dizziness	☐ headaches	☐ frequent sore throats

Respiration:
☐ **Patient DENIES having or have had any of the symptoms or problems listed below.**

☐ asthma	☐ cough	☐ wheezing	☐ coughing up blood
☐ sputum production		☐ shortness of breath	

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Cardiovascular:
☐ **Patient DENIES having or have had any of the symptoms or problems listed below.**

☐ **chest pain** ☐ **high blood pressure** ☐ **low blood pressure**

☐ **shortness of breath with exertion or exercise** ☐ **swelling of legs**

☐ **claudication (leg pain/ache)** ☐ **orthopnea (difficulty breathing lying down)**

☐ **ulcers** ☐ **heart murmur** ☐ **palpitations** ☐ **varicose veins**

☐ **heart problems** ☐ **paroxysmal nocturnal dyspnea (waking at night w/ shortness of breath)**

Gastrointestinal:
☐ **Patient DENIES having or have had any of the symptoms or problems listed below.**

☐ **abdominal pain** ☐**diarrhea** ☐ **indigestion** ☐ **abnormal stool size**

☐ **vomiting blood** ☐ **belching** ☐ **jaundice** ☐ **abnormal stool color**

☐**heart burn** ☐**nausea** ☐**constipation** ☐ **difficulty swallowing**

☐ **black-tarry stools** ☐ **hemorrhoids** ☐ **rectal bleeding** ☐ **vomiting**

☐ **abnormal stool consistency**

Female:
☐ **Patient DENIES having or have had any of the symptoms or problems listed below.**

☐ **birth control** ☐ **cramps** ☐ **irregular menstruation (periods)**

☐ **vaginal bleeding** ☐ **vaginal discharge** ☐ **frequent urination**

☐ **pregnancy** ☐ **burning urination** ☐ **hormone therapy**

☐ **urine retention**

Male:
☐ **Patient DENIES having or have had any of the symptoms or problems listed below.**

☐ **burning urination** ☐ **frequent urination** ☐ **urine retention** ☐ **hesitancy /dribbling**

☐ **prostate problems** ☐ **erectile dysfunction**

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Endocrine:
☐ **Patient DENIES having or have had any of the symptoms or problems listed below.**

☐ cold intolerance	☐ excessive hunger	☐ excessive thirst	☐ goiter
☐ diabetes	☐ hair loss	☐ voice changes	☐ unusual hair growth
☐ rash	☐ excessive appetite		☐ history of skin disorders

Skin:
☐ **Patient DENIES having or have had any of the symptoms or problems listed below.**

☐hair loss	☐ itching	☐skin lesions/ulcer	☐ changes in nail texture
☐ hives	☐ paresthesia	☐ varicosities	☐ changes in skin color
☐ hair growth	☐ rash	☐ history of skin disorders	

Nervous System:
☐ **Patient DENIES having or have had any of the symptoms or problems listed below.**

☐ dizziness	☐ limb weakness	☐ numbness	☐ slurred speech
☐ tremor	☐ facial weakness	☐ seizures	☐ loss of consciousness
☐ stress	☐ headache	☐ loss of memory	☐ sleep disturbance
☐ unsteadiness of gait/loss of balance		☐ strokes	

Psychological:
☐ **Patient DENIES having or have had any of the symptoms or problems listed below.**

☐ anxiety	☐ behavioral change	☐ convulsions	☐ memory loss
☐ depression	☐ bi-polar disorder	☐ confusion	☐mood change
☐ insomnia	☐ loss or change in appetite		

Allergy:
☐ **Patient DENIES having or have had any of the symptoms or problems listed below.**

☐ anaphylaxis	☐ itching	☐ sneezing	☐ acute nasal congestion
☐ rash	☐ food intolerance	☐ chronic nasal congestion	

Hematlogic:
☐ **Patient DENIES having or have had any of the symptoms or problems listed below.**

☐ anemia	☐ blood clotting	☐ bruising easily	☐ lymph node swelling
☐ bleeding	☐ blood transfusion	☐ fatigue	