JOINTFIT, PA

CHIROPRACTIC & SPORTS MEDICINE CENTER

Patient Name: _____ Birth Date: _____ Today's Date: _____

GENERAL REVIEW OF SYSTEMS

Have you now or have you ever had any of the conditions listed below?

	Yes Now	Yes Past	No	Comments
EYES				
Cataracts……..	☐	☐	☐	_____
Double vision……	☐	☐	☐	_____
Do you wear glasses or contact lenses? (circle)……	☐	☐	☐	_____
Itching, burning, or watering of eyes?.....	☐	☐	☐	_____
Loss of vision……	☐	☐	☐	_____
Eye pain……	☐	☐	☐	_____
Eye discharge……..	☐	☐	☐	_____
Color blindness……	☐	☐	☐	_____
History of retinal detachment/surgery……..	☐	☐	☐	_____
Date of last vision examination _____				
EARS, NOSE & THROAT				
Recurrent ears, nose or throat infections (circle)……..	☐	☐	☐	_____
Frequent nose bleeds……	☐	☐	☐	_____
Loud snoring problem ……	☐	☐	☐	_____
Sleep apnea……	☐	☐	☐	_____
Nocturnal CPAP……	☐	☐	☐	_____
Loss of hearing……	☐	☐	☐	_____
Buzzing or ringing in the ears……	☐	☐	☐	_____
Thyroid enlargement……..	☐	☐	☐	_____
Recurrent hoarseness of voice……	☐	☐	☐	_____
Neck pain or neck lumps……	☐	☐	☐	_____
Nasal allergies……	☐	☐	☐	_____
Ear discharge or bleeding……..	☐	☐	☐	_____
History of sore throats……	☐	☐	☐	_____
Difficulty swallowing……	☐	☐	☐	_____
Impaired smell or taste……..	☐	☐	☐	_____
Nasal lesions or discharge……	☐	☐	☐	_____
Sinus disease……..	☐	☐	☐	_____
Last hearing examination _____				

	Yes Now	Yes Past	No	Comments
MOUTH				
Recurrent dental problems……	☐	☐	☐	_____
Sore tongue……	☐	☐	☐	_____
Do you have dentures or bridges? (circle)……..	☐	☐	☐	_____
Bleeding gums……	☐	☐	☐	_____
Teeth, gum or oral lesions……	☐	☐	☐	_____
Do you take antibiotics for dental procedures?.....	☐	☐	☐	_____
Last dental examination _____				
RESPIRATORY				
Severe shortness of breath or wheezing……	☐	☐	☐	_____
Had cough for more then 1 month……	☐	☐	☐	_____
Chest pain when you cough hard/deep breath……..	☐	☐	☐	_____
Cough up blood……..	☐	☐	☐	_____
Blood clots in lungs……	☐	☐	☐	_____
Difficult breathing other then upright position……	☐	☐	☐	_____
Shortness of breath when exertion or at night……..	☐	☐	☐	_____
Reduced exercise tolerance……..	☐	☐	☐	_____
Daily sputum production? Color?.....	☐	☐	☐	_____
Last pulmonary function test _____				
Last chest x-ray _____				
BREAST				
Nipple discharge……	☐	☐	☐	_____
Breast pain, tenderness, or swelling……	☐	☐	☐	_____
Breast mass……	☐	☐	☐	_____
History of breast feeding……	☐	☐	☐	_____
History of breast infection or trauma……	☐	☐	☐	_____
Monthly self breast examinations……	☐	☐	☐	_____
Last physician breast examination……..	☐	☐	☐	_____
Do you know how to examine your breasts? Yes _____, No _____				
If not, would you like to be taught? Yes _____, No _____				
CARDIOVASCULAR				
Pain in the front of the chest (under sternum)……	☐	☐	☐	_____
that is heavy or pressure like?.....	☐	☐	☐	_____
that is sharp or knife like?.....	☐	☐	☐	_____
that is aggravated by exercise, stress, or anger?.....	☐	☐	☐	_____
that improves with rest or Nitro?.....	☐	☐	☐	_____
Abnormal heart beat - skipped or extra beats……	☐	☐	☐	_____
Very rapid unexplained heart beats……	☐	☐	☐	_____
Excessive fluid retention/ankle swelling……..	☐	☐	☐	_____
Impaired circulation to the legs:				
arterial, venous (circle)……..	☐	☐	☐	_____
Varicose veins……	☐	☐	☐	_____
Phlebitis (inflammation of veins)……..	☐	☐	☐	_____
Poor healing leg sores……	☐	☐	☐	_____

	Yes Now	Yes Past	No	Comments
Smothering spells relieved by sitting up……..	☐	☐	☐	_____
Difficulty breathing at night……	☐	☐	☐	_____
Blood clots (deep vein thrombosis)……..	☐	☐	☐	_____
Leg pain walking or at rest……	☐	☐	☐	_____
Color changes on fingers and/or toes……..	☐	☐	☐	_____
Congenital heart defects……	☐	☐	☐	_____
Enlarged heart or abnormal heart……	☐	☐	☐	_____

Last echocardiogram _____ performed by/at: _____

Last stress test _____ performed by/at: _____

Last cardiac catherization _____ performed by/at: _____

GASTROINTESTINAL

Recurrent indigestion, heartburn, or a sense of food regurgitation (reflux)……..	☐	☐	☐	_____
Difficulty swallowing……	☐	☐	☐	_____
Recurrent abdominal pain……..	☐	☐	☐	_____
Frequent episodes of pressure or discomfort in the upper right side of the abdomen……	☐	☐	☐	_____
Major changes in the size or bowel movements……	☐	☐	☐	_____
Constipation for more than 1 month……..	☐	☐	☐	_____
Diarrhea for more than 1 month……	☐	☐	☐	_____
Bright red blood on toilet paper or in toilet bowl……	☐	☐	☐	_____
Blood mixed in with stools……	☐	☐	☐	_____
Dark blood or black stools……	☐	☐	☐	_____
Positive stools for occult blood……..	☐	☐	☐	_____
Irritable bowel or spastic colon……..	☐	☐	☐	_____
Excessive belching or passing of gas……..	☐	☐	☐	_____
History of hemorrhoids……..	☐	☐	☐	_____
Vomiting blood……	☐	☐	☐	_____
Nausea or vomiting (circle)……	☐	☐	☐	_____
Loss of appetite……..	☐	☐	☐	_____
Food intolerance……..	☐	☐	☐	_____
Abnormal swelling……..	☐	☐	☐	_____

Last upper GI (stomach x-ray) _____

Last lower GI (barium enema x-ray) _____

UROLOGICAL

Bladder or kidney infections (circle)……	☐	☐	☐	_____
Painful urination or burning……	☐	☐	☐	_____
Blood in your urine or pus in your urine (circle)……..	☐	☐	☐	_____
Problems starting to urinate……..	☐	☐	☐	_____
Impaired, weakened urine stream……	☐	☐	☐	_____
Dribbling urine after you think you're finished……	☐	☐	☐	_____
Incontinence/leakage of urine (circle)……..	☐	☐	☐	_____
History of herpes, venereal warts, HIV, or other sexually transmitted disease (circle)……	☐	☐	☐	_____
Urinating more than once during the night……..	☐	☐	☐	_____
Bed wetting……..	☐	☐	☐	_____
Urinary frequency……	☐	☐	☐	_____

Last IVP/kidney x-ray _____

Last PSA level _____

	Yes Now	Yes Past	No	Comments

GENITOURINARY/REPRODUCTIVE

MEN ONLY

Pain or lumps in the testicles……	☐	☐	☐	_____
Problems initiating or maintaining an erection……	☐	☐	☐	_____
Do you examine your testicles at once per month?.....	☐	☐	☐	_____
Recurrent discharge at the end of the penis……...	☐	☐	☐	_____
Is there a history of sexual abuse?.....	☐	☐	☐	_____
Change in sexual activity……...	☐	☐	☐	_____

WOMEN ONLY

Your age at very first menstrual cycle _____

Date of last period _____ Age of menopause _____

Age at the time of your first pregnancy? _____

How many times have you been pregnant? _____

Number of full term pregnancies _____

Number of stillbirths/abortions _____

Number of premature births _____

Number of living children (twins?) _____

Are you pregnant now? Yes _____, No _____

Are you having irregular periods? Yes _____, No _____

Do you have heavy or prolonged periods or pass clots? Yes _____, No _____

Do you have severe cramps or pain? Yes _____, No _____

Do you have spotting or bleeding between normal menses? Yes _____, No _____

Do you use birth control medication or devices? Yes _____, No _____

If so, what kind? _____

Have you ever had a cervical or uterine biopsy? Yes _____, No _____

When _____ Results _____

Are you on hormone replacement therapy? Yes _____, No _____

If yes, date started _____

Date of last pelvic examination and Pap smear _____ Results: _____

	Yes Now	Yes Past	No	Comments

MUSCULOSKELETAL

Bursitis or tendonitis (circle)……..	☐	☐	☐	_____
Broken bones (fractures) - where?.....	☐	☐	☐	_____
Major joint injuries in knee or shoulder (circle)……...	☐	☐	☐	_____
Any artificial joints (prosthesis) (hip, knee, digits) (circle)……	☐	☐	☐	_____
Chronic back pain……...	☐	☐	☐	_____
Muscle pain……..	☐	☐	☐	_____
Muscle weakness……	☐	☐	☐	_____
Limitations on walking or running……	☐	☐	☐	_____
Joint stiffness/pain……..	☐	☐	☐	_____
Amputations (location)……...	☐	☐	☐	_____

	Yes Now	Yes Past	No	Comments
LYMPHATIC/INFECTIOUS, IMMUNOLOGIC DISEASES				
History of chronic infections/swollen lymph nodes/glands……	☐	☐	☐	_____
Measles……	☐	☐	☐	_____
Mumps……..	☐	☐	☐	_____
Chickenpox……..	☐	☐	☐	_____
Rheumatic fever……..	☐	☐	☐	_____
Scarlet fever……	☐	☐	☐	_____
HIV positive……..	☐	☐	☐	_____
Tuberculosis/positive skin test……..	☐	☐	☐	_____

Immunizations: Vaccines/Dates

Tetanus _____

Hepatitis _____

Influenza _____

Pneumonia _____

Diptheria _____

NEUROLOGICAL				
Migraine headaches……	☐	☐	☐	_____
Tension/stress headaches……	☐	☐	☐	_____
Recurrent or persistent dizziness (vertigo)……	☐	☐	☐	_____
Recurrent episodes of weakness, numbness, pain in one leg, foot, arm or hand (where?)……	☐	☐	☐	_____
Paralysis……..	☐	☐	☐	_____
Recurrent tremor or twitches……	☐	☐	☐	_____
Problems with reading comprehension or memory…...	☐	☐	☐	_____
Loss of consciousness……..	☐	☐	☐	_____
Abnormal nerve pain……..	☐	☐	☐	_____
Speech or language dysfunction……..	☐	☐	☐	_____
Loss of balance……..	☐	☐	☐	_____

SKIN/GENERAL				
History of skin cancer / type? / location?.....	☐	☐	☐	_____
Persistent or recurrent skin rashes (where?)……..	☐	☐	☐	_____
Delayed healing of skin ulcers or sores……...	☐	☐	☐	_____
Unexplained itching or hives……..	☐	☐	☐	_____
Excessive dry skin or scaling……	☐	☐	☐	_____
Change in a mole or birth mark / location?.....	☐	☐	☐	_____
Change in hair or nails - describe……	☐	☐	☐	_____
Fatigue……..	☐	☐	☐	_____
Fever or chills (circle)……..	☐	☐	☐	_____

	Yes Now	Yes Past	No	Comments
HEMATOLOGY/ONCOLOGY				
Anemia / low blood count……	☐	☐	☐	_____
Tendency for bleeding or severe bruising……	☐	☐	☐	_____
Clotting disorder……	☐	☐	☐	_____
Lymphoma / lymph node cancer……	☐	☐	☐	_____
Leukemia / blood cancer……	☐	☐	☐	_____
Low platelet count……	☐	☐	☐	_____
ENDOCRINE				
Borderline blood sugars high / low (circle)……	☐	☐	☐	_____
Calcium problems……	☐	☐	☐	_____
Thyroid nodule / cyst (circle)……	☐	☐	☐	_____
Adrenal or pituitary gland problems (circle)……	☐	☐	☐	_____
Unexplained changes in height and weight……	☐	☐	☐	_____
Heat or cold intolerance (circle)……	☐	☐	☐	_____
Changes in hair distribution or skin pigmentation (describe)……	☐	☐	☐	_____
Last thyroid profile (blood tests) _____				
Last thyroid scan, uptake and ultrasound _____				
PSYCHIATRIC				
Nervous or emotional problems……	☐	☐	☐	_____
Have you been under the care of psychiatrist or psychologist?.....	☐	☐	☐	_____
Anxiety……	☐	☐	☐	_____
Depression……	☐	☐	☐	_____
Loss of interest in your normal or fun activities……	☐	☐	☐	_____
Do you feel inadequately refreshed after a night's sleep?.....	☐	☐	☐	_____
Problems falling asleep……	☐	☐	☐	_____
Problems maintaining sleep once you have fallen asleep?.....	☐	☐	☐	_____
Loss of sexual desire……	☐	☐	☐	_____
Thoughts of worthlessness or hopelessness……	☐	☐	☐	_____
Do you find it hard to concentrate, make decisions, remember details, or get things done?.....	☐	☐	☐	_____
Do you have suicidal thoughts or plans?.....	☐	☐	☐	_____
In the past year, has a family member or close relative died?.....	☐	☐	☐	_____
Do you have panic attacks?.....	☐	☐	☐	_____

_____ _____

Patient Signature Date

_____ _____

Doctor Signature Date