Name:_______________ Date:_____________

Physical Generals and Review of Systems

(Parents should fill out this form for young children based on observation. Children over 4 or 5 years old can be asked some of the questions. Please then write their answers, plus your own observations).

FOOD:

1. What foods do you especially like, or crave (even if you don't eat them)?

2. What foods do you dislike?

3. What foods disagree with or aggravate you in some way?

4. How is your appetite? Poor, average, high? Specify.

5. Any problems with digestion? Specify.

6. Any problems if you go too long without eating (headache, shakiness, etc.), and how many hours can you go without eating before getting these symptoms?

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Thermal State:

1. Which do you tolerate the LEAST: extreme hot weather, or extreme cold weather? Please specify if either causes or aggravates any symptoms.

Is this a lifelong tendency, or has it changed in recent years?

2. Are you affected by a draft of air? How?

3. Does any particular weather affect you (rainy/damp, hot and humid, dry, windy, etc.)? How?

4. How do you like or tolerate the direct sun? Any symptoms if in it too long?

5. Do thunderstorms affect you? How?

6. How do you feel at the ocean? Any improvement in symptoms there?

7. Any reaction to moon phases?

8. Any dislike for a particular season (Spring, Fall, etc.), or seasonal worsening of symptoms?

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9. Any desire for open air (fresh air, open windows, bedroom window cracked, etc.)? How strong?

PERSPIRATION:

1. Circle one: Absent Mild Moderate Heavy

2. In what particular areas do you perspire?
   Head Back Chest Groin Hands Feet

3. Any particular odor to the perspiration? Describe.

4. Any stains left on clothing or sheets? Describe>

ENERGY:

1. On average, where does your energy usually fall on the following scale (circle):

can hardly get out of bed					average			plenty each day	
1	2	3	4	5	6	7	8	9	10

2. What is your best time of day or night?

3. Worst time of day or night?

4. Does anything else modify your energy (make it better or worse)? Explain.

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5. On average, how is your motivation to do things you need and want to do each day (circle):

none		could be better				pretty good			excellent
1	2	3	4	5	6	7	8	9	10

SLEEP:

1. Any problems falling asleep at night? Describe.

2. Any problems staying asleep all night? Describe, and include if you usually wake at a certain time.

3. What is your preferred position to sleep in? Why?

4. Any position you cannot sleep in? Why not?

5. In your sleep, do you (circle):
   snore talk grind teeth sweat drool move a lot

   stick feet out of covers put arm(s) over/under your head

6. Do you wake refreshed in the morning?

7. How easy or difficult do you find it to wake up? How long does it take to feel fully awake most days?

8. Do you prefer to have covers on? Can you sleep without them in warm weather?

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9. Do you recall dreams? If so, relate any recurring or themes (even back in childhood). Also, please describe any recent dream, including any feeling you had in the dream.

PSYCHOSOCIAL HISTORY:

Please take your time with this section, and answer with as much honesty as possible. Using specific examples is most helpful. Use the back of the page or attach a page if needed.

1. What about others do you admire the most (or is there someone on particular you admire or have looked up to)? Why?

2. What about others annoys you or do you dislike? This could be a character trait, or something people do that really irks you.

3. How do you express your anger? What triggers it? How have you expressed it at your worst?

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4. When upset about something, do you prefer to be left alone, or to have someone available for talking/consolation?

5. How do you respond to music? How intense is your response?

6. How much do like or desire to travel?

7. How important is someone else's opinion of you (what others think of you)?

8. Briefly describe your relationship with your father (now and/or in the past):

9. Briefly describe your relationship with your mother (now and/or in the past):

10. Briefly describe any other significant relationships or life circumstances that affect you now (and/or have affected you in the past):

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11. Briefly describe your spiritual/religious beliefs:

12. Have you ever dealt with any addiction issues (personally, or with family members)? What addiction?

13. Describe your nature when you were a child? What were you like? What affected you?

14. If you feel this applies to your health, complete the following sentence: “I have never been well since…”:

15. Is there anything else that you feel affects your health now?

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Physical Generals and Review of Systems

FEARS: Circle any of the following common fears that you currently have, or had as a child:

Dark   Storms   Ghosts   Being alone

Basements   Dogs   Cats   Snakes

Spiders   Birds   Mice/rats   Other animals

Doctors   Dentist   Needles   Blood

Health issues in general   Cancer   Heart Disease   Germs

Death   Others dying (family)   Accidents   Robbers

Poverty   Failure   Public speaking   Taking tests

Heights   Narrow places (claustrophobia)   Water   Crowds

Bridges   Airplanes   Insanity   Vague sense of foreboding

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Please list any other fears:

Do you have any particular worries that you don’t consider fears? Be specific please.

REVIEW OF SYSTEMS

Please indicate whether you have any problems in the following areas (or had problems in the past). Please give a brief description, especially if the area is an intense or recurrent problem.

1. HEAD:

____ Headaches
____ Migraines
____ Dandruff
____ Other:

2. EYES:

____ Blurry vision
____ Itchy eyes
____ Light sensitivity
____ Pain
____ Dryness
____ Redness
____ Other

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Physical Generals and Review of Systems

3. EARS:
_____ Ringing
_____ Infections
_____ Hearing problems
_____ Excess wax
_____ Discharge
_____ Itching
_____ Other:

4. NOSE:
_____ Sense of smell (acute, lost, etc)
_____ Sinus pain
_____ Discharge
_____ Stuffiness
_____ Sneezing
_____ Allergies
_____ Bloody noses
_____ Crusts inside
_____ Other:

5. MOUTH/THROAT:
_____ Sense of taste (altered, lacking, bad taste in mouth, etc.)
_____ Teeth (pain or other problems)
_____ Tongue
_____ Bleeding gums
_____ Canker sores

_____ Sore throats
_____ Change in voice
_____ Cold sores (herpes)
_____ Bad breath
_____ Trouble swallowing
_____ Lump sensation in throat
_____ Other:

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6. NECK:
_____ Sensitive to anything snug worn at neck
_____ Thyroid issues
_____ Neck pain
_____ Stiffness
_____ Other:

7. CHEST:
_____ Chest pains
_____ Heart palpitations
_____ Shortness of breath
_____ Wheezing
_____ Cough
_____ Breast tenderness
_____ Breast lumps
_____ Other:

8. ABDOMEN/GI:
_____ Appetite
_____ Heartburn/reflux
_____ Belching
_____ Nausea
_____ Stomach pain
_____ Bloating/distention
_____ Abdominal pain
_____ Ulcers
_____ Constipation/difficult stool
_____ Diarrhea
_____ Flatulence
_____ Hemorrhoids
_____ Change in stool (color, consistency, shape, etc.)
_____ Sensitive to anything snug worn around waist
_____ Other:

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9. GU/FEMALE:

_____ Heavy menstruation
_____ Painful menstruation
_____ PMS
_____ Vaginal discharge
_____ History of STD's
_____ Menopause/Perimenopause
_____ Sex drive (libido)
_____ Fertility issues
_____ How old were you at your first period?
_____ How old at menopause?
_____ Number of pregnancies
_____ Number of miscarriages
_____ Other problems that would get worse around periods
_____ Other problems with periods
_____ Urinary tract/bladder infections
_____ Blood in urine
_____ Urinary incontinence
_____ How many times do you urinate in the night?

10. GU/MALE:

_____ Trouble urinating (starting, force of stream, incomplete emptying, etc.)
_____ Incontinence
_____ History of STD's
_____ Prostate issues
_____ Testicular pain or swelling
_____ Blood in urine
_____ Erections
_____ Sex drive (libido)
_____ How many times do you urinate during the night?
_____ Other:

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Physical Generals and Review of Systems

11. MUSCULOSKELETAL/EXTREMITIES:

_____ Body stiffness
_____ Joint pains
_____ Muscle pain
_____ Low back pain
_____ Other back pain
_____ Sciatica
_____ Muscle cramps
_____ Swelling/edema
_____ Significant injury in the past
_____ Other:

12. SKIN/INTEGUMENT:

_____ Acne
_____ Eczema
_____ Psoriasis
_____ Ringworm
_____ Dry skin
_____ Itchy skin
_____ Easy bruising
_____ Discoloration
_____ Skin infections/boils/cellulitis
_____ Moles, skin tags
_____ Skin cancer
_____ Nails (soft, slow growing, split, brittle, ridged, etc.)
_____ Hangnails
_____ Ingrown toenails
_____ Toenail fungus
_____ Sensitivity to metals
_____ Tendency to poison ivy
_____ Hair falling out
_____ Hair went gray early
_____ Hair very dry/breaks/slow growing

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13. Neurologic:
_____ Fainting or feeling faint
_____ Seizures
_____ Tremors
_____ Balance problems
_____ Numbness
_____ Weakness
_____ Tingling
_____ Restless legs (awake or in bed)
_____ Other:

14. MENTAL/EMOTIONAL:
_____ Depression
_____ Anxiety
_____ Anger
_____ Irritability
_____ Mood changes
_____ Concentration/focus
_____ Memory
_____ Confusion
_____ Change in behavior
_____ Other:

GENERAl:
_____ Weight gain (unintended)
_____ Weight loss (unintended)
_____ Fever
_____ Chills
_____ Night sweats
_____ Sleep problems
_____ Fatigue
_____ Anemia
_____ Reaction to vaccination
_____ Oversensitive to medications
_____ Oversensitive to chemicals/odors
_____ Other:

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