



Review of Systems - Adult

Briefly, what issues would you like addressed, please rank them in order of importance afterwards.

1. _____
2. _____
3. _____
4. _____
5. _____

On the questions below, please circle Yes or No and/or circle all the symptoms that apply!

Please rank your energy, on a scale from 1-10 with 10 being high energy: _____

Do you have trouble getting out of bed in the morning? **Yes** or **No**

Are you **wired & tired** at night? **Yes** or **No**

Do you have trouble sleeping? **Yes** or **No**

Do you have problems with **falling asleep, staying asleep, snoring, restless legs**? **Yes** or **No**

Do you use a **CPAP/BIPAP**? **Yes** or **No**

How many hours a night do you sleep? _____ Weekdays? _____ Weekends? _____

Are you having any **fevers, chills, nausea, vomiting**? **Yes** or **No**

Have you had any worrisome **weight gain** or **weight loss**? **Yes** or **No** How much? _____

Are you having any **headaches, sinus problems, post-nasal drip**? **Yes** or **No**

Any **ear, nose** and **throat problems, swollen glands, or difficulty swallowing**? **Yes** or **No**

Any **vision, hearing, smelling** or **taste disturbances**? **Yes** or **No**

Do or Did you have **metal fillings** in your mouth? **Yes** or **No**

Do you see a **Biologic Dentist**? **Yes** or **No**

Have you had any **root canals, dental implants** or **current dental problems**? **Yes** or **No**

Do you have any **chest pain (at rest or with activity), palpitations, racing** or **skipped beats**? **Yes** or **No**

Do you have **high blood pressure, high cholesterol, or other heart problems**? **Yes** or **No**

Do you have any **shortness of breath (at rest or upon exertion), wheezing** or **cough**? **Yes** or **No**

Do you have **pneumonitis, bronchitis, asthma** or **other lung problems**? **Yes** or **No**

Do you **feel cold** when others are hot? **Yes** or **No**

Do you **feel hot** when others are cold? **Yes** or **No**

Do you have any problems with your **nails, hair loss** or **too much hair**? **Yes** or **No**

Do you have any **acne, warts, moles, vitiligo, psoriasis** or **excessive sweating**? **Yes** or **No**



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Do you have any **rashes, hives, eczema, or other skin issues**? **Yes** or **No**

Do you have any **diarrhea, constipation, incomplete evacuation, gas or bloating**? **Yes** or **No**

Do you have **abdominal pain, heartburn or indigestion**? **Yes** or **No**

Do you have **candida, SIBO, parasites, viruses, leaky gut, histamine intolerance**? **Yes** or **No**

How often do you have a bowel movement? _____ Bristol Stool Chart # _____

Are you having **menstrual periods**? **Yes** or **No** How often? _____

Are they **heavy, medium, light**? How long do they last? _____

Do you get **breast tenderness or cramps**? **Yes** or **No**

Do you have any **PMS** (irritable, emotional)? **Yes** or **No** How many days prior to your period? _____

What do you and your partner use for **birth control**? _____

Are you **trying to get pregnant**? **Yes** or **No**

Are you **having trouble getting pregnant**? **Yes** or **No**

Do you have **hot flashes, night sweats, vaginal dryness or need for a sexual lubricant**? **Yes** or **No**

Where would you **rank your sex drive** (from **0 to 10**, 10 being high)? _____ **Your partner's**? _____

Are you having any difficulties with **erectons, intercourse, ejaculation or orgasm**? **Yes** or **No**

Is sex a **fulfilling and/or pleasurable experience**? **Yes** or **No**

Is sex an **issue** in your relationship? **Yes** or **No**

On a **scale from 0-10**, 10 being wedded bliss and 0 being time to find a new mate, where would you **rank your relationship**? _____ How do you think **your partner** would rank it? _____

Do you have **urinary symptoms, urgency, hesitancy, frequency, dribbling or bed-wetting**?

Do you have to get up at night to urinate? **Yes** or **No** How many times a night? _____

Do you lose urine if you **cough or sneeze**? **Yes** or **No** If your bladder is too full? **Yes** or **No**

Do you have any **bleeding disorders, easy bruising, hemorrhoids**? **Yes** or **No**

Do you get **frequent infections**? **Yes** or **No**

Have you had **Mono**? **Yes** or **No**

Do you get any **yeast infections**? **Yes** or **No**

Have you ever used an **antibiotic for an extended period of time** (e.g. acne, TB, sinus)? **Yes** or **No**

When was the last time you used an antibiotic? _____ Which one? _____

Do you suffer from **food allergies, sensitivities or intolerances**? **Yes** or **No**

Do you have any **cravings**, such as **sugar, chocolate, carbs, salt, fats, protein, alcohol**? **Yes** or **No**

Do you have inhalant allergies (**dust, mites, molds, pollens, animals, grasses, trees, weeds, tobacco, perfumes, chemicals**)? **Yes** or **No**

Have you had allergy shots? **Yes** or **No**



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Do you have much exposure to **chemicals, molds, high electromagnetic fields, tobacco, drugs?**

Do you have any **MEDICATION ALLERGIES? Yes or No** To What? _____

Do you have any **joint pain, fibromyalgia, arthritis, or muscle weakness? Yes or No**

Do you have **pain** anywhere in your body? **Yes or No** Where? _____

On a scale of **0-10**, with 10 being extreme pain, how much pain do you have? _____

Do you have any **swelling? Yes or No** Where? _____

Do you have any problems with **cold hands, feet or entire body?**

Do you have any **fuzzy thinking, attention disorder, problems focusing, or learning disabilities?**

Have you had any **brain trauma, concussions or falls? Yes or No**

Do you have any memory loss? **Yes or No** **Short-term, long-term?** _____

Do you have **dizziness, fainting, seizures, strokes, "blackouts" or loss of consciousness?**

Do you have any **numbness or unusual sensations** (pins and needles)?

Are you happy? Yes or No

On a scale from **0-10**, 10 being severe depression, where would you rank your **depression?** _____

On a scale from **0-10**, 10 being severe anxiety, where would you rank your **anxiety?** _____

On a scale from **0-10**, 10 being severe stress, where would you rank your **stress?** _____

How do you usually unwind? _____

Do you view yourself as an **optimist** or **pessimist?**

Have you experienced any **trauma, abuse, molestation, neglect, violence or major stress? Yes or No**

Is there a family history of **cancer, Alzheimer's, dementia, heart disease, high blood pressure, high cholesterol, stroke, autoimmune disease, miscarriages, clotting disorders, obesity, alcoholism, mental illness or genetic diseases?**

What else should I know about you?

Do you have any allergies (including medications)? **Yes or No**

If yes, list source and type of reaction, e.g. **sulfa > rash, bee sting > anaphylaxis** (throat swells shut):

- | | |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |



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Are you taking any prescription meds or shots (e.g. **insulin, Depo-Provera, allergy shots**)? **Yes** or **No**
If yes, please list drug, dosage, and how often you take it:

Medication	Amount (e.g. mg)	How often
1. _____		
2. _____		
3. _____		
4. _____		
5. _____		
6. _____		
7. _____		
8. _____		

Are you taking any vitamins, minerals, and/or supplements? **Yes** or **No**

Name	Amount	How often
1. _____		
2. _____		
3. _____		
4. _____		
5. _____		
6. _____		
7. _____		
8. _____		
9. _____		
10. _____		
11. _____		
12. _____		
13. _____		