Global Medicine
Monique Martin, D.O., Integrative Internist

Review of Systems - Teen 13-19 years old

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 **cardiac 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**, **emphysema**, **COPD**, **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**, **rosacea**, **moles**, **vitiligo**, **psoriasis** or **excessive sweating**? **Yes** or **No**

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**

499 W. Belleview Ave. Englewood, CO 80110 Phone 303.762.7206

How often do you have a bowel movement? _____

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? _____

Is someone touching you against your will? **Yes** or **No**

Are you sexually active? **Yes** or **No**

Are you practicing safe sex? **Yes** or **No** or **Sometimes**

Are you or your partner using birth control? **Yes** or **No** or **Sometimes**

Are you in a relationship? **Yes** or **No**

Is it a positive experience? **Yes** or **No**

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

Do you have **hot flashes**, **night sweats**, **vaginal dryness**? **Yes** or **No**

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

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**

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** 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)?

499 W. Belleview Ave. Englewood, CO 80110 Phone 303.762.7206

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. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____

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**	**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.			

499 W. Belleview Ave. Englewood, CO 80110 Phone 303.762.7206