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Review of Systems

Height: _____
 Weight: _____
 Weight change in the past year? _____
 Maximum weight? When? _____
 Minimum weight? When? _____
 What do you feel is the most comfortable weight for you? _____

Please check if you currently have the symptom, or indicate **P** if it has been a problem in the past:

<u>Skin, Hair and Nails</u>		<u>Digestion and Elimination</u>	
	acne		Change in appetite
	changes in skin odor		Excessive/diminished thirst
	Changes in hair/nails		Excessive/diminished hunger
	Cradle cap		Trouble chewing/swallowing
	Eczema, rashes		Frequent vomiting
	Hives, itching		Stomach/abdominal aches
Other:			Excessive belching
<u>Eyes, Ears, Nose and Throat</u>			Excessive gas
	Sore throat/mouth/tongue		# bowel movements/day
	Coughing		Constipation
	Lumps/swollen glands		Diarrhea
	Discharge (eyes, ears, nose, etc)		Hemorrhoids
	Nose bleeds		Food allergies
	Impaired vision/ Blurred vision	Other:	
	Loss of balance	<u>Urination</u>	
	Eye pain		Blood in urine
	Hearing problems		Burning/pain on urination
	Frequent ear infections		Increased frequency
	Wheezing or difficulty breathing		Kidney stones
	Sinus problems		Urgency
	Changes in taste		Frequent infections
Other:		Other:	
<u>Respiratory</u>		<u>Cardiovascular</u>	
	Shortness of breath		Heart disease
	Bronchitis		Chest pain
	Pneumonia		High blood pressure
	Asthma		Murmurs
	Tuberculosis		Palpitations
Other:			Ankle swelling
<u>Mental and Emotional</u>		Other:	
	Cries easily or weepy	<u>Neurological</u>	
	Irritable		Fainting
	Memory problems		Seizures
	Nervousness		Numbness/tingling
	Nightmares or night terrors	Other:	
	Strong fears or aversions	<u>General</u>	
	Sudden changes in mood		Heat/cold intolerance
Other:			Excessive sweating/ Night sweats

Muscle and Skeleton		Motion sickness
Backache		Anemia
Change in posture/gait		Easy bruising/ Slow wound healing
Joint pain/stiffness		Headaches
Muscle pain/stiffness		Body or breath odor
Muscle pain/stiffness		Weight changes
Other:	Other:	

If you have mercury amalgams, how many do you have?

Date of last dental exam? _____

Date of last eye exam? _____

Sleep Habits

How many hours of sleep do you get on average? _____

Do you wake feeling rested? YES or NO

Do you have difficulty falling asleep at night? YES or NO

If yes, why do you think this is? _____

Do you ever take anything to help you to sleep? YES or NO

If yes, what? _____

Do you wake up during the night? YES or NO

If yes, at what time do you typically wake up? _____

Why do you wake up? _____

Are you able to get back to sleep right away? YES or NO

If not, what do you do? _____

Do you remember your dreams? YES or NO

If yes, describe the nature of your dreams? _____

Sexuality

How would you describe your libido (sexual desire)? _____

Have you ever experienced pain during intercourse? YES or No'

If yes, please describe _____

Have you ever experienced sexual dysfunction? YES or No

If yes, please describe _____

Are you currently sexual active? YES or NO

Do you have more than one partner? YES or NO _____

Do you use birth control and/or other methods of birth control? Please describe: _____

Sexual preference: _____

Please indicate which of the following make you feel better or worse:

Better	Worse		Better	Worse	
		Winter			Spring
		Summer			Autumn
		Cold			Heat

		Damp			Storms
		Sun			Wind
		Fresh air			Indoors
		Weather change			Moonlight
		Seaside			Mountains
		Activity			Morning
		Afternoon			Evening
		Night			Traveling
		Warm applications			Cold applications
		Before menses			Onset of menses
		During menses			After menses
		Pressure			

Please use words or pictures to describe yourself: