Linglestown Chiropractic · Dr. Ryan Semendinger · 4456 Oakhurst Blvd · Harrisburg, PA 17110

REVIEW OF SYSTEMS

Patient Name _____ Date _____

Gastrointestinal

Nausea	No	Yes
Vomiting	No	Yes
Heartburn	No	Yes
Painful swallowing	No	Yes
Vomiting blood	No	Yes
Abnormal stool	No	Yes
Abdominal pain	No	Yes
Diarrhea	No	Yes
Loss of appetite	No	Yes
Bloating	No	Yes

Constitutional

Recent weight gain	No	Yes
# of pounds _____		
Recent weight loss	No	Yes
# of pounds _____		
Fever	No	Yes
Fatigue	No	Yes

Neurological

Seizures	No	Yes
Headaches	No	Yes
Tremors	No	Yes
Unsteady gait	No	Yes

Dermatological

Rash	No	Yes

ENT

Sore throat	No	Yes
Hoarseness	No	Yes

Cardiovascular

Arrhythmia	No	Yes
Chest pain	No	Yes
Palpitations	No	Yes

Respiratory

Cough	No	Yes
Shortness of breath on exertion	No	Yes
Shortness of breath at rest	No	Yes
Wheezing	No	Yes

Genitourinary

Frequent urination	No	Yes
Kidney failure	No	Yes
Painful urination	No	Yes

Musculoskeletal

Joint pain	No	Yes
Arthritis	No	Yes

Psychiatric

Dementia	No	Yes
Depression	No	Yes
Anxiety	No	Yes

Medical History

Ascites	No	Yes
Asthma	No	Yes
Bleeding disorder	No	Yes
Cancer	No	Yes
Emphysema	No	Yes
Gallstones	No	Yes
Heart attack	No	Yes
High blood pressure	No	Yes
Kidney stones	No	Yes
Liver disease	No	Yes
Pancreatitis	No	Yes
Stroke/TIA	No	Yes
Thyroid disease	No	Yes

Others _____

_____

Please complete the other side

Other Medical History

Do any of your family members have a history of cancer? _____

Have you had any surgeries? _____

Use of alcohol: **None** **Occasional** **Daily**

Use of tobacco: **None** **Occasional** **Daily**

Current prescription medications: _____

_____

_____

_____

Are you taking any blood thinners? **No** **Yes**

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

Authorization and Release

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I authorize the health staff to perform the necessary services I may need and release information to others if necessary for my care.

Patient signature _____ Date _____