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**REVIEW OF SYSTEMS**

Circle either Y (yes for I have this symptom), N (no because you've never had this symptom) or P (meaning you had this symptom in the past).  
 Try to answer the questions as accurately as possible but only answers the questions you feel comfortable answering.

**GENERAL**

Loss of appetite	Y	N	P	
Loss of consciousness	Y	N	P	
Chills	Y	N	P	
Fatigue	Y	N	P	
Fainting	Y	N	P	
Insomnia	Y	N	P	
Fever	Y	N	P	
General weakness	Y	N	P	
Weight:	Minimum:		When?	_____
	Maximum:		When?	_____

**SKIN/HAIR/NAILS**

Masses	Y	N	P
Moles	Y	N	P
Change in mole?	Y	N	P
Rashes	Y	N	P
Itching	Y	N	P
Dryness	Y	N	P
Brittle nails	Y	N	P
Eczema	Y	N	P
Psoriasis	Y	N	P
Slow wound healing	Y	N	P
Excessive sweating	Y	N	P
Change in nails	Y	N	P
Change in hair	Y	N	P
Changes in temperature	Y	N	P
Hives	Y	N	P
Acne	Y	N	P

**HEAD**

Headache	Y	N	P
Head Injury	Y	N	P
Dizziness	Y	N	P
TMJ concerns	Y	N	P
Lightheadedness	Y	N	P
Migraines	Y	N	P

**EYES**

Impaired vision	Y	N	P	
Use of corrected lenses	Y	N	P	Near sighted or Far sighted _____
Pain	Y	N	P	
Double vision	Y	N	P	
Glaucoma	Y	N	P	
Sties	Y	N	P	
Cataracts	Y	N	P	
Itching	Y	N	P	
Floaters	Y	N	P	
Difficulty with bright lights	Y	N	P	
Colour blindness	Y	N	P	
Night blindness	Y	N	P	
Blurry vision	Y	N	P	
Droopy eyelid (s)	Y	N	P	
Halos (ring around lights)	Y	N	P	
Blind spots	Y	N	P	
Impaired peripheral vision	Y	N	P	
Redness	Y	N	P	
Tearing	Y	N	P	
Discharge	Y	N	P	

**EARS**

Pain	Y	N	P
Deafness/hearing loss	Y	N	P
Discharge	Y	N	P
Infections	Y	N	P
Tinnitus (ringing)	Y	N	P
Vertigo (dizziness)	Y	N	P
Itching	Y	N	P
Use of hearing aid	Y	N	P

**NOSE/SINUSES**

Runny nose	Y	N	P
Stuffiness	Y	N	P
Discharge	Y	N	P
Redness	Y	N	P
Itching	Y	N	P
Nose bleeds	Y	N	P
Pain over sinuses	Y	N	P
Hay fever	Y	N	P
Frequent colds/infections	Y	N	P

**MOUTH/THROAT**

Sores	Y	N	P
Sore throats	Y	N	P
Hoarseness	Y	N	P
Dental caries	Y	N	P
Cold sores	Y	N	P
Loss of teeth	Y	N	P
Dentures	Y	N	P
Change in taste	Y	N	P
Bad taste	Y	N	P
Malodorous breath	Y	N	P
Bleeding	Y	N	P
Dry mouth	Y	N	P

Number of fillings?

Material used? \_\_\_\_\_

**NECK**

Pain	Y	N	P
Swelling	Y	N	P
Stiffness	Y	N	P
Lumps	Y	N	P

**RESPIRATORY**

Cough	Y	N	P
Sputum	Y	N	P
Coughing up blood	Y	N	P
Wheezing	Y	N	P
Asthma	Y	N	P
Emphysema	Y	N	P
Bronchitis	Y	N	P
Pneumonia	Y	N	P
Tuberculosis	Y	N	P
Pleurisy	Y	N	P
Lung abscess	Y	N	P
Shortness of breath	Y	N	P
Trouble breathing at night	Y	N	P

Last chest x-ray? \_\_\_\_\_

**CARDIOVASCULAR**

History of heart disease	Y	N	P
Chest pain	Y	N	P
Swelling (ankles, hands)	Y	N	P
Cyanosis (blue skin)	Y	N	P
Palpitations	Y	N	P
Loss of consciousness	Y	N	P
High blood pressure	Y	N	P
Low blood pressure	Y	N	P
Heart murmur	Y	N	P
Varicose veins	Y	N	P

Stroke

Y

N

P

**GASTROINTESTINAL**

Abdominal pain	Y	N	P
Pain on swallowing	Y	N	P
Heartburn	Y	N	P
Indigestion	Y	N	P
Bloating	Y	N	P
Nausea	Y	N	P
Vomiting	Y	N	P
Jaundice	Y	N	P
Food intolerance	Y	N	P
Diarrhea	Y	N	P
Constipation	Y	N	P
Bloody stools	Y	N	P
Mucus in stools	Y	N	P
Excessive belching	Y	N	P
Excessive passing of gas	Y	N	P
Incontinence	Y	N	P
Hemorrhoids	Y	N	P
Rectal itching/burning	Y	N	P
Rectal discharge	Y	N	P
Rectal pain	Y	N	P
Hepatitis	Y	N	P
Gall bladder disease	Y	N	P
Liver concerns	Y	N	P
Ulcer	Y	N	P

Change in bowel habits? \_\_\_\_\_  
How many stools/day? \_\_\_\_\_ per week? \_\_\_\_\_

**URINARY**

Pain on urination	Y	N	P
Blood in urine	Y	N	P
Change in colour	Y	N	P
Urination at night	Y	N	P
Little or no urine	Y	N	P
Lower back pain	Y	N	P
Retention (can't fully void)	Y	N	P
Urgency	Y	N	P
Hesitancy	Y	N	P
Incontinence	Y	N	P
Passage of stones	Y	N	P
Past infections	Y	N	P

Frequency urination? (# times/day) \_\_\_\_\_

**BREAST**

Lumps	Y	N	P
Pain	Y	N	P
Swelling	Y	N	P
Nipple discharge	Y	N	P
Perform self-breast exams	Y	N	P

Last breast exam? \_\_\_\_\_  
Last mammogram? \_\_\_\_\_

**FEMALE**

Amenorrhea (loss of perio)	Y	N	P
Menorrhagia (excessive flk)	Y	N	P
Irregular periods	Y	N	P
Dysmenorrhea (painful per)	Y	N	P
PMS	Y	N	P
Contraceptive use	Y	N	P
Vaginal discharge	Y	N	P
Itching	Y	N	P
Yeast infections	Y	N	P
Lesions/sores	Y	N	P
Herpes	Y	N	P
STDs/infections	Y	N	P
Pelvic Inflammatory Disea	Y	N	P
Sexually active	Y	N	P
Problems with intercourse	Y	N	P
Pain with intercourse	Y	N	P
Hot flashes	Y	N	P
Menopausal symptoms	Y	N	P

How many times have you been pregnant? \_\_\_\_\_  
How many live births? \_\_\_\_\_  
Age of first menses? \_\_\_\_\_  
Usual length of cycle? \_\_\_\_\_  
Amount of flow? \_\_\_\_\_  
Last menstrual period? \_\_\_\_\_  
Age of menopause? \_\_\_\_\_  
HIV status? \_\_\_\_\_  
Do you receive regular PAPs? \_\_\_\_\_  
Last PAP? \_\_\_\_\_  
Sexual orientation? \_\_\_\_\_

**MALE**

Hernias	Y	N	P
Penile discharge	Y	N	P
Itching	Y	N	P
Abscess	Y	N	P
Lesions/sores	Y	N	P
Herpes	Y	N	P
STDs/infections	Y	N	P
Testicular pain or lumps	Y	N	P
Problems with intercourse	Y	N	P
Pain with intercourse	Y	N	P
Contraceptive use	Y	N	P
Sexually active	Y	N	P
Prostate trouble	Y	N	P

Sexual orientation? \_\_\_\_\_

Last testicular exam? \_\_\_\_\_

Last DRE? \_\_\_\_\_

**ENDOCRINE**

Goiter (enlarged thyroid gl)	Y	N	P
Hot intolerance	Y	N	P
Cold intolerance	Y	N	P
Tremor	Y	N	P
Excessive sweating	Y	N	P
Change in voice	Y	N	P
Skin changes	Y	N	P
Change in hair distribution	Y	N	P
Increased thirst	Y	N	P
Increased hunger	Y	N	P
Thyroid disorders	Y	N	P

**MUSCULOSKELETAL**

Pain in an extremity	Y	N	P
Joint pain	Y	N	P
Joint swelling	Y	N	P
Limited range of motion	Y	N	P
History of arthritis	Y	N	P
Joint redness	Y	N	P
Muscle pain	Y	N	P
Gout	Y	N	P
Backache	Y	N	P

If yes, explain. \_\_\_\_\_

History of broken bones? \_\_\_\_\_

History of sprains? \_\_\_\_\_

**NEUROLOGICAL**

Seizures	Y	N	P
Uncoordinated movement	Y	N	P
Frequent falling	Y	N	P
Involuntary movement	Y	N	P
Altered sensation	Y	N	P
Loss of muscle mass	Y	N	P
Paralysis	Y	N	P
Clumsiness	Y	N	P
Numbness	Y	N	P

**HEMATOLOGICAL**

Anemia	Y	N	P
Easy bruising	Y	N	P
Past transfusions	Y	N	P
IV drug use	Y	N	P
Enlarged lymph nodes	Y	N	P
Bleeding disorder	Y	N	P

**MENTAL/EMOTIONAL**

Nervousness	Y	N	P
Anxiety	Y	N	P
Mood swings	Y	N	P
Depression	Y	N	P
Panic episodes	Y	N	P
Disturbing/unusual though	Y	N	P
Problems sleeping	Y	N	P