

**WHOLSOME WELLNESS**  
Dr. Julia Gill, Bsc. (Hon), ND  
Naturopathic Doctor

**REVIEW OF SYSTEMS**

Please mark "C" for current symptoms, "P" if you have in the past.

◆ **Generals**

Current weight: _____	Current height: _____
___ noticeable weight loss	___ fatigue
___ noticeable weight gain	___ weakness
___ fever	

◆ **Skin**

___ rashes	___ colour change	___ lumps
___ changes in hair/nails	___ itching	___ dryness
___ eczema	___ hives	___ psoriasis
___ boils	___ moles	

◆ **Head**

___ head injury	___ headaches
___ hair loss	___ dandruff

◆ **Eyes**

___ redness	___ spots	___ pain
___ specks	___ excessive tearing	___ flashing lights
___ double vision	___ glaucoma	___ blurred vision
___ cataracts	___ crossed eyes	___ blind spot
___ discharge	___ bothered by the sun	

Do you wear glasses/contacts? \_\_\_\_\_

Date of last eye exam? \_\_\_\_\_

◆ **Ears**

___ infection	___ ringing in ears (tinnitus)	___ vertigo
___ discharge	___ earaches	___ hearing loss

Do you use hearing aids? \_\_\_\_\_ Date of last hearing test? \_\_\_\_\_

◆ **Nose and Sinuses**

___ frequent colds	___ hay fever	___ nosebleeds
___ nasal stuffiness	___ discharge	___ itching
___ loss of smell	___ sinus infections	

◆ **Mouth and Throat**

___ dry mouth	___ bleeding gums
___ sore tongue	___ hoarseness
___ spots/sores in mouth	___ dental cavities
___ heat/cold intolerance	___ sore throat
___ lumps in neck	___ loss of taste
___ tonsillitis	___ enlarged thyroid
___ stiff neck	

Date of last dental exam? \_\_\_\_\_

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◆ **Respiratory**

- |                                       |   |
|---------------------------------------|---|
| <input type="checkbox"/> sputum       | <input type="checkbox"/> cough                |
| <input type="checkbox"/> hemoptysis   | <input type="checkbox"/> bronchitis           |
| <input type="checkbox"/> wheezing     | <input type="checkbox"/> emphysema            |
| <input type="checkbox"/> asthma       | <input type="checkbox"/> pneumonia            |
| <input type="checkbox"/> tuberculosis | <input type="checkbox"/> pleurisy             |
| <input type="checkbox"/> chest pain   | <input type="checkbox"/> difficulty breathing |

Results of spirometry tests or other lung tests: \_\_\_\_\_

◆ **Cardiovascular**

- |  |   |
|--|---|
| <input type="checkbox"/> rapid heart beat            | <input type="checkbox"/> slow heart beat      |
| <input type="checkbox"/> high blood pressure         | <input type="checkbox"/> heart murmurs        |
| <input type="checkbox"/> low blood pressure          | <input type="checkbox"/> rheumatic fever      |
| <input type="checkbox"/> chest pain                  | <input type="checkbox"/> edema/swollen ankles |
| <input type="checkbox"/> palpitations                | <input type="checkbox"/> difficulty breathing |
| <input type="checkbox"/> blueness of skin (cyanosis) | <input type="checkbox"/> cold hands/feet      |
| <input type="checkbox"/> thrombophlebitis            | <input type="checkbox"/> extremity numbness   |
| <input type="checkbox"/> deep leg pain               | <input type="checkbox"/> leg cramps           |

Results of electrocardiogram or other heart tests: \_\_\_\_\_

◆ **Gastrointestinal**

- |  |  |
|--|--|
| <input type="checkbox"/> trouble swallowing      | <input type="checkbox"/> hemorrhoids                   |
| <input type="checkbox"/> heart burn              | <input type="checkbox"/> constipation                  |
| <input type="checkbox"/> excessive hunger/thirst | <input type="checkbox"/> diarrhea                      |
| <input type="checkbox"/> poor appetite/thirst    | <input type="checkbox"/> hypoglycemia                  |
| <input type="checkbox"/> diabetes                | <input type="checkbox"/> abdominal pain                |
| <input type="checkbox"/> nausea                  | <input type="checkbox"/> food intolerance/allergy      |
| <input type="checkbox"/> vomiting                | <input type="checkbox"/> excessive belching            |
| <input type="checkbox"/> regurgitation           | <input type="checkbox"/> passing of gas                |
| <input type="checkbox"/> vomiting of blood       | <input type="checkbox"/> jaundice                      |
| <input type="checkbox"/> indigestion             | <input type="checkbox"/> liver or gallbladder problems |
| <input type="checkbox"/> hepatitis               | <input type="checkbox"/> colitis                       |
| <input type="checkbox"/> ulcer                   | <input type="checkbox"/> hernias                       |
| <input type="checkbox"/> excessive bloating      |  |

Frequency of bowel movements? \_\_\_\_\_

Colour and size of stools? \_\_\_\_\_

Change in bowel habits? \_\_\_\_\_

Any recent bleeding or black tarry stools? \_\_\_\_\_

◆ **Genito-Urinary**

- |  |   |
|--|---|
| <input type="checkbox"/> dark-coloured urine       | <input type="checkbox"/> blood in urine     |
| <input type="checkbox"/> excessive urination       | <input type="checkbox"/> frequency at night |
| <input type="checkbox"/> burning/pain on urination | <input type="checkbox"/> kidney infection   |

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pus in urine  
 urgency  
 dribbling  
 urinary infections

foul smelling urine  
 hesitancy  
 incontinence  
 kidney stones

◆ **Musculoskeletal**

muscle or joint pains  
 arthritis  
 back pain  
 broken bones  
 general muscle weakness

stiffness  
 gout  
 artificial joints/limbs  
 muscle spasms/cramps  
 joint swelling

◆ **Neurological**

fainting/blackouts  
 weakness  
 numbness/loss of sensation  
 tremors/involuntary motion  
 nervousness  
 depression  
 difficulties concentrating  
 convulsions/seizures

loss of balance  
 paralysis  
 tingling/pins and needles  
 speech problems  
 tension  
 memory changes/loss  
 irritability  
 loss of sleep

◆ **Hematological**

anemia  
 easy bleeding

any past transfusions  
 easy bruising