GEM
Integrative Wellness

Dr. Galina Mahlis, ND

Review of Systems

Please check all that apply to you **CURRENTLY**:

General: ❑Weakness ❑Fatigue ❑Change in weight/appetite ❑Fever/chills ❑Night sweats ❑Hot/cold intolerance ❑Increased thirst/hunger/urination ❑Change in sleeping habits ❑Anemia ❑Bleeding tendencies

Other: _____

Skin: ❑Rashes ❑Lumps ❑Sores ❑Itching ❑Dryness ❑Change in moles ❑Changes in hair/nails ❑Easy bruising

Other: _____

Head: ❑Head injury ❑Headache ❑Migraines ❑Dizziness ❑Head Injury ❑Hair Loss ❑History of loss of consciousness ❑Seizures

Other: _____

Eyes: ❑Watery/itchy/red eyes ❑Discharge from eyes ❑Double Vision ❑Blurriness in vision ❑Use of glasses/contacts ❑Cataracts ❑Glaucoma ❑Sensitivity/pain to light or vision changes

Date of last eye exam: _____ Other: _____

Ears: ❑Ear pain ❑Discharge ❑Infection ❑Hearing changes/impairment ❑Tinnitus ❑Vertigo

Other: _____

Nose/Sinuses: ❑Chronic sinusitis ❑Hay fever ❑Decreased smell ❑Excessive congestion ❑Nosebleeds ❑Nasal fractures

Other: _____

Mouth/Throat: ❑Tenderness or lesions ❑Sore throats ❑Burning sensation of tongue ❑Difficult/painful swallowing ❑Persistent hoarseness ❑Tooth pain ❑Bleeding gums ❑Brush/floss daily ❑Dentures ❑Root canal ❑Dental implant

Other: _____

Neck: ❑History of injury ❑Masses ❑Pain ❑Stiffness

Other: _____

Chest: ❑Cough ❑Chest pain ❑Shortness of breath ❑Wheezing ❑Sputum ❑History of asthma ❑Bronchitis ❑Coughing up blood ❑Pneumonia ❑Tuberculosis (TB)

Other: _____

Cardiac: ❑High blood pressure ❑Low blood pressure ❑History of chest pain ❑Murmurs ❑Palpitations ❑Dizziness ❑Fainting ❑Shortness of breath with exertion (DOE) ❑Congestive Heart Failure ❑Shortness of breath while lying down (orthopnea) ❑Coronary Artery Disease ❑Stroke/TIA ❑Heart attack

Other: _____

Vascular: ❑Pain in legs/hips while walking ❑Edema ❑Coolness/discoloration of legs/arms ❑Loss of hair on legs ❑Blue/purple colored skin (cyanosis) ❑Ulcers/non-healing wounds ❑Varicose veins ❑ Deep vein thrombosis (blood clots)

Other: _____

Gastrointestinal: ❑Abdominal pain ❑Nausea/vomiting ❑Change in appetite ❑Food intolerance ❑Heartburn ❑Vomiting blood (hematemesis) ❑Excessive belching ❑Excessive passing gas ❑Constipation ❑Diarrhea ❑Change in stool ❑Hemorrhoids ❑Rectal bleeding/pain

Other: _____

Have you gained or lost over ten pounds in the past year? ❑ Yes ❑ No Was this on purpose? ❑ Yes ❑ No

Esophagogastroduodenoscopy (EGD): ❑ Yes ❑ No Year: _____ What were the findings? _____

Colonoscopy: ❑ Yes ❑ No Year: _____ What were the findings? _____

Urinary: ❑Pain with urination (dysuria) ❑Frequent urination ❑Urgency ❑Blood in urine ❑Change in urine color/odor ❑Infections ❑Kidney stones ❑Difficulty initiating stream ❑Incontinence

Other: _____

Musculoskeletal: ❑Weakness ❑Muscle/joint pain or stiffness ❑Limitation of movement ❑Arthritis ❑Back pain ❑Muscle cramps

Other: _____

Neurological: ❑Fainting ❑Dizziness ❑Blackouts ❑Paralysis ❑Numbness ❑Tingling/burning ❑Tremors ❑Speech disorders ❑Memory loss ❑Mood changes ❑Psychiatric disorders ❑Hallucinations ❑Seizures

Other: _____

MALES:

❑Pain/lesions on genitals ❑Discharge from penis ❑Erectile dysfunction ❑Deceased libido ❑Testicular masses/pain/swelling ❑Hernias ❑Decreased force of urinary stream ❑Sexually transmitted infection ❑Prostate Disease ❑Sexually active Do you have sex with: ❑Men ❑Women ❑Both

Date of last prostate or rectal exam: _____ What were the findings? _____

FEMALES:

Breasts: ❑Lumps ❑Discharge ❑Pain ❑Prior surgery or biopsy ❑Breast cancer ❑Family history of breast cancer

Mammogram: ❑ Yes ❑ No Year: _____ What were the findings? _____

Thermography: ❑ Yes ❑ No Year: _____ What were the findings? _____

Female health: ❑Vaginal discharge ❑Vaginal itching/burning ❑Lesions on genitalia ❑Pain with sexual intercourse ❑Low libido ❑Sexually transmitted infection

Pregnancy: ❑Complications ❑Birth Difficulties How many pregnancies? ____ How many live births? ____ How many abortions? _____ How many miscarriages? _____ Any complications: _____

_____

Menses: ❑Menstrual cramps ❑Menstrual pain ❑PMS ❑Food Cravings ❑Heavy bleeding ❑Decreased libido ❑Breast tenderness ❑Breast Lumps ❑Edema ❑Irritability ❑Depression Age of first period: _____

Are you sexually active? ❑ Yes ❑ No Do you have sex with: ❑Men ❑Women ❑Both

Birth Control/contraception (type): _____

Date of last Pap Smear: _____ Have you ever had an abnormal Pap? _____ If so, when? _____

Menopause: ❑Vaginal dryness ❑Pain with intercourse ❑Hot flashes ❑Weight gain ❑Irritability ❑Night sweats ❑Menopausal since: _____

❑Hormone Replacement Therapy (type/duration) _____

Have you had a hysterectomy? ❑ Yes ❑ No Year: _____ If yes, do you have ovaries? ❑ Yes ❑ No

Bone Density (DEXA): ❑ Yes ❑ No Year: _____ What were the findings? _____

Please list any other information you feel is important to share:

_____

_____

I have indicated all of my known medical conditions above. I will alert the practitioner to any changes in my health status. It is my choice to receive naturopathic care.

_____ _____

(Patient/patient's representative signature) **(Date)**

Indicate relationship if signing on behalf of patient: _____

_____ _____

(Printed name of patient/patient's representative **(Date)**