**David Byers, D.C.**          **Byers Family Chiropractic**

# GENERAL SYSTEMS REVIEW

Patient: _____          Date:_____

**Respiratory**
Past Present
- t☐ ☐ Smoker
- ☐ ☐ Allergies
- ☐ ☐ Asthma
- ☐ ☐ Bronchitis
- ☐ ☐ Cough
- ☐ ☐ Emphysema
- ☐ ☐ Frequent Colds
- ☐ ☐ Hay fever
- ☐ ☐ Pneumonia
- ☐ ☐ Tuberculosis

**Skin**
Past Present
- ☐ ☐ Acne Problems
- ☐ ☐ Dermatitis
- ☐ ☐ Eczema
- ☐ ☐ Fungal Infection
- ☐ ☐ Herpes
- ☐ ☐ Polyps
- ☐ ☐ Psoriasis
- ☐ ☐ Shingles
- ☐ ☐ Botox Injection

**Vision**
Past Present
- ☐ ☐ Glaucoma
- ☐ ☐ Light Sensitivity
- ☐ ☐ Blurred Vision
- ☐ ☐ Cataracts
- ☐ ☐ Double Vision
- ☐ ☐ Dyslexia

**Cardiovascular**
Past Present
- ☐ ☐ Angina
- ☐ ☐ Arrhythmia's
- ☐ ☐ Arteriosclerosis
- ☐ ☐ Blood Clots
- ☐ ☐ Chest pain
- ☐ ☐ Hypertension
- ☐ ☐ Rheumatic
- ☐ ☐ Heart Attack
- ☐ ☐ CHF
- ☐ ☐ High Cholesterol

**Head**
Past Present
- ☐ ☐ Concussion
- ☐ ☐ Headaches
- ☐ ☐ Insomnia
- ☐ ☐ Learning Problem
- ☐ ☐ Memory Problem
- ☐ ☐ Mental Illness

**Gastro-intestinal**
Past Present
- ☐ ☐ Appendicitis
- ☐ ☐ Appetite loss
- ☐ ☐ Black Stool
- ☐ ☐ Blood in Stool
- ☐ ☐ Constipation
- ☐ ☐ Chron's
- ☐ ☐ Colitis
- ☐ ☐ Diarrhea
- ☐ ☐ Heart Burn
- ☐ ☐ Gall Bladder Problem
- ☐ ☐ IBS
- ☐ ☐ Stomach Cramps
- ☐ ☐ Ulcers

**Urinary**
Past Present
- ☐ ☐ Bladder infections
- ☐ ☐ Blood in Urine
- ☐ ☐ Incontinence
- ☐ ☐ Infections
- ☐ ☐ Kidney Stones
- ☐ ☐ Yeast Infection

**Vascular**
Past Present
- ☐ ☐ Anemia
- ☐ ☐ Easy Bleeding
- ☐ ☐ Hemorrhoids
- ☐ ☐ Raynaud's
- ☐ ☐ Thromophlebitis
- ☐ ☐ Transfusions
- ☐ ☐ Varicose Veins

**Musculoskeletal**
Past Present
- ☐ ☐ Non-Specific Back Ache
- ☐ ☐ Disc Problems
- ☐ ☐ Fractures
- ☐ ☐ Gout
- ☐ ☐ Joint Pain
- ☐ ☐ Muscle Cramps
- ☐ ☐ Muscle Injury
- ☐ ☐ Paralysis
- ☐ ☐ Neck pain
- ☐ ☐ Osteoarthritis
- ☐ ☐ Osteoporosis
- ☐ ☐ Rheumatism
- ☐ ☐ Rheumatoid
- ☐ ☐ Scoliosis
- ☐ ☐ Fibromyalgia
- ☐ ☐ Chronic Fatigue

**Endocrine**
Past Present
- ☐ ☐ Diabetic
- ☐ ☐ Hyperthyroid
- ☐ ☐ Hypothyroid
- ☐ ☐ Adrenal Problem
- ☐ ☐ Others

**Female Reproductive**
Past Present
- ☐ ☐ Pregnant
  Due Date:
- ☐ ☐ Fibroids
- ☐ ☐ PID
- ☐ ☐ Hysterectomy
- ☐ ☐ Menopause
- ☐ ☐ STD
- ☐ ☐ Fertility Problems

**Male Reproductive**
Past Present
- ☐ ☐ Impotence
- ☐ ☐ Testicular Pain
- ☐ ☐ Prostate Problem
- ☐ ☐ STD
- ☐ ☐ Urination Trouble

**Neurological**
Past Present
- ☐ ☐ Epilepsy
- ☐ ☐ Parkinson's
- ☐ ☐ Concussion
- ☐ ☐ Seizures
- ☐ ☐ Alzheimer's
- ☐ ☐ Multiple Sclerosis

**Others**
Past Present
- ☐ ☐ Alcoholic
- ☐ ☐ Cancer
- ☐ ☐ Chemotherapy
- ☐ ☐ Depression
- ☐ ☐ Hepatitis
- ☐ ☐ ADD/ADHD
- ☐ ☐ Radiation Therapy
- ☐ ☐ AIDS
- ☐ ☐ HIV Positive

**Family History**
- ☐ Arthritis
- ☐ Genetic Problems
- ☐ Auto immune condition
- ☐ High Blood Pressure
- ☐ Diabetes
- ☐ High Cholesterol
- ☐ Hypothyroidism
- ☐ Hyperthyroidism
- ☐ Heart Attack
- ☐ Stroke
- ☐ Vascular Problems
  Others

**Childhood Conditions**
- ☐ Measles
- ☐ Mumps
- ☐ Chicken Pox
- ☐ Whooping Cough
- ☐ Scarlet Fever
- ☐ Diphtheria
- ☐ Typhoid , Rheumatic Fever
- ☐ Recurrent Ear Infections
- ☐ Chronically Ill
- ☐ Asthma
- ☐ Allergies
- ☐ Others

## Exercise History

How many days per week are you exercising?
- ☐ None
- ☐ 1-2 days a week
- ☐ 3-4 days a week
- ☐ 5 or more days a week

Do you lift weights on a regular basis?
☐ Yes ☐ No

Do you perform core stabilization exercises on a regular basis?
☐ Yes ☐ No

Do you practice certain relaxation techniques on a regular basis?
☐ Yes ☐ No

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