**Medical Review of Systems**

Please place a check mark in the boxes that apply. Explain any problem areas.

### General
- Being overweight
- Recent weight gain or weight loss
- Poor appetite
- Increased appetite
- Abnormal sensitivity to cold
- Cold sweats during the day
- Tired or worn out
- Hot or cold spells
- Abnormal sensitivity to heat
- Excessive sleeping
- Difficulty sleeping
- Lowered resistance to infection
- Flu-like or vague sick feeling
- Sweating excessively at night
- Urinating excessively
- Excessive daytime sweating
- Excessive thirst
- Other______________________

### Neurological
- Pacing due to muscle restlessness
- Forgotten periods of time
- Dizziness
- Drowsiness
- Muscle spasms or tremors
- Impaired ability to remember
- “Tics”
- Numbness
- Convulsions / fits
- Slurred speech
- Speech problem (other)
- Weakness in muscles
- Other______________________

### Respiratory
- Asthma, wheezing
- Cough
- Coughing up blood or sputum
- Shortness of breath
- Rapid breathing
- Repeated nose or chest colds
- Other______________________

### Chest and Cardiovascular
- Ankle swelling
- Rapid / irregular pulse
- Breast tenderness
- Chest pain
- High blood pressure
- Low blood pressure
- Other______________________

### Head, Eye, Ear, Nose, & Throat
- Facial pain
- Headache
- Head injury
- Neck pain or stiffness
- Frequent sore throat
- Blurred vision
- Double vision
- Overly sensitive to light
- See spots or shadows
- Hearing loss in both ears
- Ear ringing
- Disturbances in smell
- Runny nose
- Dry mouth
- Sore tongue
- Other______________________

### Gastrointestinal and Hepatic
- Trouble swallowing
- Nausea or vomiting (throwing up)
- Abdominal (stomach / belly) pain
- Anal itching
- Painful bowel movements
- Infrequent bowel movements
- Liquid bowel movements
- Loss of bowel control
- Frequent belching or gas
- Vomiting blood
- Rectal bleeding (red or black blood)
- Jaundice (yellowing of skin)
- Other______________________

### Musculoskeletal
- Back pain or stiffness
- Bone pain
- Joint pain or stiffness
- Leg pain
- Muscle cramps or pain
- Other______________________

### Skin, Hair
- Dry hair or skin
- Itchy skin or scalp
- Easy bruising
- Hair loss
- Increased perspiration
- Sun sensitivity
- Other______________________

### Genitourinary
- Itchy privates or genitals
- Painful urination
- Excessive urination
- Difficulty in starting urine
- Accidental wetting of self
- Pus or blood in urine
- Decreased sexual desire
- Other______________________

### Females
- No menses
- Menstrual irregularity
- Painful or heavy periods
- Premenstrual moodiness, irritability, anger, tension, bloating, breast tenderness, cramps, headache
- Painful menstrual periods
- Painful intercourse or sex
- Sterility infertility
- Abnormal vaginal discharge
- Other______________________

### Males
- Impotence (weak male erection)
- Inability to ejaculate or orgasm
- Scrotal pain
- Abnormal penis discharge
- Other______________________

### Explanation
________________________
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Kim Kendall, Ph.D. 1 of 3
OTHER MEDICAL HISTORY INFORMATION

Current medical problems/medications:__________________________________________
________________________________________________________________________
________________________________________________________________________

Current supplements/vitamins/herbs:__________________________________________
===============================================================================

Past medical problems/medications:__________________________________________
________________________________________________________________________
________________________________________________________________________

Other doctors/clinics seen regularly:__________________________________________

Any history of head trauma, falls, car accidents, dazed, concussion, loss of oxygen or
toxin exposure? (describe & list your age at the time):__________________________
________________________________________________________________________

Ever any seizures or seizure like activity?____________________________________
________________________________________________________________________

Prior hospitalizations (place, cause, date, outcome):____________________________
________________________________________________________________________

Prior abnormal lab tests, X-rays, EEG, etc:____________________________________

Other comments or concerns related to your general health:

List mood, emotional or substance use related problems you are concerned about:
________________________________________________________________________
________________________________________________________________________

List what services you have used before to address any of those issues:
________________________________________________________________________
________________________________________________________________________

List any emotional, mood, or temper problems that others in your extended family have
had and who had those issues:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

List other relevant information here:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
PRIOR PSYCHIATRIC MEDICATIONS/SUPPLEMENTS (Please list all medications/supplements taken alone and all medications taken in combination; including dosages, effectiveness and any side-effects.)

<table>
<thead>
<tr>
<th>DATE TAKEN</th>
<th>MEDICATION(S) - Individual or Combinations - Dosage(s) and time(s) taken</th>
<th>EFFECTIVENESS</th>
<th>SIDE-EFFECTS &amp; PROBLEMS</th>
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<tbody>
<tr>
<td>Example: 2/00 - 5/04</td>
<td>Example: • Ritalin 5 mg 2x/day • Prozac 10mg in am</td>
<td>Example: Improved concentration in morning, still moody</td>
<td>Example: Felt very unfocused in evening; hyperactive in evenings; dry mouth</td>
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