Review Of Systems: Mark an x if you are currently or recently experienced any of the following:

General Symptoms	Eyes	Musculoskeletal
☐ Tired, weak, lack of energy	☐ Blurred vision	☐ Muscle pain
☐ Depression,	☐ Night blindness	☐ Weakness
☐ Headaches, migraines	☐ Pain in eyes	☐ Joint swelling
☐ Dizziness, fainting, blacking out	**Ears**	☐ Joint stiffness
☐ Night sweats	☐ Noises or ringing in ears	☐ Numbness or tingling
Skin and Hair	☐ Ear discharge	**Urinary**
☐ Hives	☐ Loss of hearing	☐ Difficulty urinating
☐ Skin ulcers or sores	**Nose and Throat**	☐ Frequent Urination
☐ Dry, rough or scaling skin	☐ Loss of smell or taste	☐ Pain when urinating
☐ Warts, moles or skin tags	☐ Cavities	☐ Blood in urine
☐ Cuts heal slowly or scar badly	☐ Difficulty swallowing	**Cardiovascular**
Gastrointestinal	**Chest**	☐ Tightness in chest
☐ Nausea or vomiting	☐ Difficulty breathing	☐ Swollen feet, ankles or legs
☐ Bloating or gas	☐ Chest pain or palpitations	☐ Hands or feet turn blue
☐ Constipation/Diarrhea	☐ Wheezing	☐ High blood pressure
☐ Undigested food in stool	☐ Wet cough	**Male**
☐ Blood in stool or on paper		☐ Prostate issues
☐ Rectal pain/itching		☐ Rashes or sores
		Female
		☐ Lumps in breasts
		☐ Vaginal discharge, pain, itching
		☐ Pelvic pain

Past Medical Conditions: Mark an x to the left of any condition you have had in the past

☐	Alcoholism	☐	Epilepsy	☐	Liver Disease
☐	Arthritis	☐	Gallbladder Disease	☐	Mastectomy
☐	Asthma	☐	Glaucoma	☐	Pacemaker
☐	Bleeding Disorders	☐	Gout	☐	Pneumonia
☐	Cancer	☐	Heart Disease	☐	Prostate Problems
☐	Congestive Heart Failure	☐	High Cholesterol	☐	Stroke
☐	COPD/Emphysema	☐	HIV/AIDS positive	☐	Thyroid Condition
☐	Dialysis	☐	Kidney Disease	☐	Tonsillitis
☐	Diabetes	☐	Kidney/bladder infection	☐	Ulcers

I certify that the above information is correct to the best of my knowledge.

Print Name:

Signature:

Date:

GREENCIRCLE
wellness center

Contact Information

Name:

Date:

Age + Date Of Birth:

Height + Weight:

Gender:

Marital Status + # of Children:

Address, City, State, Zip:

Cell Phone Number:

Email Address:

Emergency Contact Information

Emergency Name:

Phone Number

Other Information

Primary Care Doctor:

Phone Number:

Health Concerns Today:

Hospitalization/Surgeries + Date:

Current Medications/Supplements

Please List:

Any drug or food allergies:

Any family members have a history of chronic disease

Social History

Sleep (hrs/night) + Quality:

Water (oz/day):

Exercise:

Soda:

Coffee:

Tobacco:

Alcohol:

Drugs: