Harbour Healthcare, Inc.

719 High Street, Suite 118
Portsmouth, VA 23704
(PHONE) 866.601.4443 (FACSIMILE) 866.596.6056
www.myharbourhealthcare.com

(double click here on header and complete name/date)

Name: **Preferred/Nickname:** **Date:** / /

Comprehensive Review Of Systems

Any questions you feel uncomfortable answering or to discuss confidentially, please mark with a "Z" in details field

GENERAL:

Do you or have you ever had	Yes	No	Details (if applicable)
Any weight loss? (<5 lbs in one week)?	☐	☐	
Any weight gain? (>5 lbs. in one week)?	☐	☐	
Feeling fatigue, weakness or feeling 'drained'?	☐	☐	
Are you susceptible to fevers?	☐	☐	
Night sweats?	☐	☐	
Sports injuries?	☐	☐	
Use of a cane or walker?	☐	☐	
Concussions?	☐	☐	
Osteoarthritis?	☐	☐	
Anxiety or Panic Attacks?	☐	☐	
Cancer?	☐	☐	
Diabetes?	☐	☐	
Heart attacks?	☐	☐	
Stroke?	☐	☐	
Autoimmune disorders?	☐	☐	
Disc herniations or bulge?	☐	☐	
Broken Bones?	☐	☐	
Surgeries (minor, major, cosmetic)?	☐	☐	
Vehicular accidents (including minor injuries)?	☐	☐	
Smoker (including vaping, cigars, pipe, etc.)?	☐	☐	
Drink alcohol?	☐	☐	
Other?	☐	☐	

MUSCULOSKELETAL:

Do you or have you ever had	Yes	No	Details (if applicable)
Back pain?	☐	☐	
Neck pain?	☐	☐	
Mid-back pain?	☐	☐	
Muscle weakness?	☐	☐	
Pain or stiffness: upon wakening?	☐	☐	
Pain or stiffness: during any physical activity?	☐	☐	
Pain or stiffness: after or during driving?	☐	☐	
Pain or stiffness: after working at a computer?	☐	☐	
Pain or stiffness: in your extremities?	☐	☐	
Pain or stiffness: any position?	☐	☐	
Joint pain or swelling?	☐	☐	

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Pinpoint deep pain in or near a bone?	☐	☐	
Tears (rotator cuff, ACL, etc.)?	☐	☐	
TMJ or jaw pain?	☐	☐	
Other?	☐	☐	

EYES/EARS/NOSE/THROAT:

Do you or have you ever had	**Yes**	**No**	**Details (if applicable)**
Ringing in your ears?	☐	☐	
Sudden or long-term loss of hearing?	☐	☐	
Pain or dryness in, around or behind eyes?	☐	☐	
Loss of or blurry vision?	☐	☐	
Sore throats?	☐	☐	
Hoarseness or change in your vocal tone?	☐	☐	
Difficulty swallowing?	☐	☐	
Nasal congestion?	☐	☐	
Runny noses sudden or more than a few days?	☐	☐	
Frequent or extremely robust sneezing?	☐	☐	
Other?	☐	☐	

HEART AND LUNGS:

Do you or have you ever had	**Yes**	**No**	**Details (if applicable)**
Chest pain?	☐	☐	
Palpitations/flutters with/without exercising?	☐	☐	
Shortness of breath?	☐	☐	
Fainting?	☐	☐	
Dizziness/lightheaded from *sitting to standing*?	☐	☐	
Dizziness/lightheaded from *lying down to sitting*?	☐	☐	
Persistent coughs or wheezing?	☐	☐	
Irregular heartbeats?	☐	☐	
Heart failure?	☐	☐	
Swollen legs, feet or other joints?	☐	☐	
COPD (Chronic Pulmonary Lung Disease)?	☐	☐	
Bronchitis?	☐	☐	
Emphysema?	☐	☐	
Asthma?	☐	☐	
Pneumonia?	☐	☐	
Other?	☐	☐	

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NERVOUS SYSTEM:

Do you or have you ever had	Yes	No	Details (if applicable)
Headaches?	☐	☐	
Numbness or tingling?	☐	☐	
Dizziness, disorientation or fainting?	☐	☐	
Trigeminal Neuralgia?	☐	☐	
Epilepsy/Seizures?	☐	☐	
Peripheral Neuropathy?	☐	☐	
Bell's Palsy?	☐	☐	
Asperger's?	☐	☐	
Subdural Hematoma?	☐	☐	
Vertigo?	☐	☐	
Sleep apnea? Snoring?	☐	☐	
Other?	☐	☐	

STOMACH AND INTESTINES:

Do you or have you ever had	Yes	No	Details (if applicable)
Nausea?	☐	☐	
Heartburn?	☐	☐	
Stomach pain?	☐	☐	
Vomiting?	☐	☐	
Yellow (jaundice)?	☐	☐	
Constipation?	☐	☐	
Diarrhea?	☐	☐	
Ulcers?	☐	☐	
Bloody stools?	☐	☐	
Black stools?	☐	☐	
Intestinal parasites?	☐	☐	
Fibromyalgia?	☐	☐	
IBS (Irritable Bowel Syndrome)?	☐	☐	
IBD (Inflammatory a/k/a Crohn's)?	☐	☐	
GERD (GastroEsophageal Reflux Disease)?	☐	☐	
Gluten Sensitivity?	☐	☐	
Hemorrhoids?	☐	☐	
Other?	☐	☐	

SKIN:

Do you or have you ever had	Yes	No	Details (if applicable)
Redness or rashes?	☐	☐	
Liver Spots?	☐	☐	

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Nodules or Bumps?	☐	☐	
Changes with or rapid hair loss?	☐	☐	
Color changes (blue, pale, etc.) in extremities?	☐	☐	
Moles?	☐	☐	
Melanoma?	☐	☐	
Rosacea?	☐	☐	
Lupus?	☐	☐	
Eczema?	☐	☐	
Hives?	☐	☐	
Fungal nail infections?	☐	☐	
Cellulitis?	☐	☐	
Shingles?	☐	☐	
Other?	☐	☐	

BLOOD:

Do you or have you ever had	Yes	No	Details (if applicable)
Anemia?	☐	☐	
Clots?	☐	☐	
DVT (Deep Vein Thrombosis)?	☐	☐	
Lymphoma?	☐	☐	
Leukemia?	☐	☐	
Color changes (blue, pale, etc.) in extremities?	☐	☐	
Multiple Myeloma?	☐	☐	
Other?	☐	☐	

KIDNEY/URETER/BLADDER:

Do you or have you ever had	Yes	No	Details (if applicable)
Frequent or painful urination?	☐	☐	
Blood in urine?	☐	☐	
Persistent back pain in your flanks?	☐	☐	
Dehydration?	☐	☐	
Bladder infections?	☐	☐	
Very dark or overly light urine?	☐	☐	
Abdominal pain? Excessive bloating or gas?	☐	☐	
Other?	☐	☐	

PSYCHIATRIC:

Do you or have you ever had	Yes	No	Details (if applicable)
Excessive worries?	☐	☐	
Difficulty falling asleep or staying asleep?	☐	☐	
Unusual appetites or cravings?	☐	☐	

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Crying jags without provocation?	☐	☐	
Situational stress?	☐	☐	
Poor concentration?	☐	☐	
ADD/ADHD?	☐	☐	
Hallucinations?	☐	☐	
Mood swings?	☐	☐	
Depression (situational or long term)?	☐	☐	

FEMALE ONLY

	Yes	No	Details (if applicable)
Age of first period?	☐	☐	(approximate month/year) _____/_____
Have you ever or do you have PMS?	☐	☐	
Are you currently pregnant?	☐	☐	If yes, how many weeks/months?
Your last menstrual cycle began?			MM/~DD/YY _____
Within the last 10 days?	☐	☐	
Are you menopausal?	☐	☐	If yes, began~? _____
Pregnancies?	☐	☐	_____
Miscarriages?	☐	☐	_____

I, _____***,***

PRINT

certify that the information provided on this form, and providing to on any subsequent information with Harbour Healthcare, is true to the best of my knowledge.

_____ _____

SIGNATURE *WITNESS*