

Patient Name _____

Date _____

SYMPTOMS Please check any of these symptoms you have experienced in the last 6 months.

General

- Fever/Chills
- Night Sweats
- Fatigue
- Weight Loss or Gain
- Rashes

Ear, Eye, Nose, Throat

- Poor/Blurred Vision
- Pain in eye(s)
- Deafness/Difficulty Hearing
- Nosebleeds
- Horseness

Gastrointestinal

- Poor Appetite
- Poor Digestion
- Difficulty Swallowing
- Belching or Gas
- Frequent Nausea
- Vomiting
- Vomiting Blood
- Pain Over Abdomen
- Black or Bloody Stool
- Jaundice
- Diarrhea
- Constipation

Respiratory

- Difficulty In Breathing
- Chronic Cough/Bronchitis
- Productive Cough

Cardiovascular

- Ankle Swelling
- Chest Tightness/Pain

Genitourinary

- Frequent Urination
- Painful Urination
- Blood in Urine
- Inability to Control Urination
- Difficulty Starting Urine Flow
- Get Up at Night to Urinate

Musculoskeletal

- Neck Stiffness/Pain
- Pain Between Shoulders
- Low Back Pain
- Swollen Joints
- Painful Joints
- Muscle Aches/Soreness

Skin

- Itching
- Bruising Easily
- Change in Mole(s)

Neurologic

- Weakness
- Tremors
- Dizziness
- Numbing/Tingling
- Arm/Leg Pain

Women Only

- Painful Periods
- Excessive Flow
- Irregular Cycles
- Vaginal Burning/Itching
- Hot Flashes
- Breast Lump
- Date Last Period Began
- Date of Last Pap Smear

Men Only

- Testicular Swelling/Pain
- Breast Lump

FAMILY HISTORY (Do not include yourself (Include Information on brothers, sisters, parents, grandparents))

- | | | |
|---|---|--|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Thyroid Disease/Goiter | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Seizures/Stroke | <input type="checkbox"/> Muscle, Bone or Nerve Disease |
- Miscellaneous _____

DIAGNOSIS - Please check if you have ever been diagnosed with any of the following

General

- Allergies
- Bleeding Problems
- Anemia
- Diabetes
- Cancer
- Thyroid Disease/Goiter
- Alcoholism
- Drug Abuse
- Anorexia/Bulemia
- Chicken Pox

Ear, Eye, Nose, Throat

- Sinus Infection
- TMJ
- Cataracts
- Glaucoma

Musculoskeletal

- Rheumatoid Arthritis
- Degenerative Arthritis

Gastrointestinal

- Ulcer
- Liver Problems
- Gall Bladder Problems
- Hernia
- Hemorrhoids
- Appendicitis

Respiratory

- Wheezing/Asthma
- Pneumonia
- Tuberculosis
- Emphysema

Cardiovascular

- Irregular Heartbeat
- High Blood Pressure
- Rheumatic Fever
- Stroke
- Heart Attack/Heart Disease

Genitourinary

- Kidney Disease
- Urinary Infection
- STD
- AIDS,HIV,Hepatitis

Neurologic

- Headache/Migraine
- Epilepsy/Seizures
- Depression/Anxiety Disorders
- Multiple Sclerosis

Women Only

- Miscarriage

Skin

- Skin Cancer

Men Only

- Prostate Problems

