

Have you experienced any of the following:

PLEASE ANSWER ALL QUESTIONS

CONSTITUTIONAL

Good general health lately..... No Yes
Recent weight change..... No Yes
Fever..... No Yes
Fatigue..... No Yes
Headaches..... No Yes

Date

MUSCULOSKELETAL

Joint pain..... No Yes
Joint stiffness or swelling..... No Yes
Weakness of muscles or joints... No Yes
Muscle pain or cramps..... No Yes
Back pain..... No Yes
Cold extremities..... No Yes
Difficulty in walking.... No Yes

Date

EYES

Eye disease or injury..... No Yes
Wear glasses/contact lens..... No Yes
Blurred or double vision..... No Yes
Glaucoma..... No Yes

SKIN

Rash or itching..... No Yes
Change in skin color.. No Yes
Change in hair or nails..... No Yes
Varicose veins..... No Yes
Breast pain..... No Yes
Breast lump..... No Yes
Breast discharge..... No Yes

ENT

Hearing loss..... No Yes
Ringing in the ears.... No Yes
Earaches or drainage..... No Yes
Sinus problems..... No Yes
Nose bleeds..... No Yes
Mouth sores..... No Yes
Bleeding gums..... No Yes
Bad breath or bad taste..... No Yes
Sore throat or voice change..... No Yes
Swollen glands in neck..... No Yes

NEUROLOGICAL

Frequent or recurring headaches. No Yes
Light headed or dizzy. No Yes
Convulsions or seizures..... No Yes
Numbness or tingling sensations No Yes
Tremors..... No Yes
Paralysis.. No Yes
Stroke..... No Yes

CARDIOVASCULAR

Heart Surgery..... No Yes
Chest pains..... No Yes
Sudden heart beat changes..... No Yes
Swelling of feet, ankles or hands No Yes
History of Heat attack..... No Yes

PSYCHIATRIC

Memory loss or confusion..... No Yes
Nervousness..... No Yes
Depression..... No Yes
Sleep problems..... No Yes

RESPIRATORY

Frequent coughing.... No Yes
Spitting up blood..... No Yes
Shortness or breath... No Yes
Asthma or wheezing.. No Yes

ENDOCRINE

Glandular or hormone problem... No Yes
Thyroid disease..... No Yes
Excessive thirst or urination..... No Yes
Heat or cold intolerance..... No Yes
Dry Skin... No Yes
Change in hat or glove size..... No Yes

GASTROINTESTINAL

Loss of Appetite..... No Yes
Change in bowel movements..... No Yes
Nausea or vomiting... No Yes
Frequent diarrhea..... No Yes
Painful bowel movements or constipation.... No Yes
Blood in stool..... No Yes
Stomach pain..... No Yes

HEMATOLOGIC/LYMPHATIC

Slow to heal after cuts..... No Yes
Easily bruise or bleed. No Yes
Anemia... No Yes
Phlebitis... No Yes
Past transfusion..... No Yes
Enlarged glands..... No Yes

GENITOURINARY

Frequent urination..... No Yes
Burning or painful urination..... No Yes
Blood in urine..... No Yes
Change of force of strain when urinating..... No Yes
Incontinence or dribbling..... No Yes
Kidney stones..... No Yes
Male - testicle pain.... No Yes
Female - painful or irregular period..... No Yes
Female - Last Menstrual period..... No Yes
Nite time urination (more than twice a nite)..... No Yes

List any medications you are now taking.

ALLERGIES

Patient Signature: _____

Provider Signature: _____

I have reviewed and confirmed this information with the patient.

