

Patient Name: _____ File #: _____ Date: _____

Please the box for any conditions or symptoms **presently** causing you problems.

Please the box for any conditions or symptoms **that you have had in the past**.

<p>General Symptoms</p> <input type="checkbox"/> Loss of consciousness <input type="checkbox"/> Blackouts <input type="checkbox"/> Headache <input type="checkbox"/> Fever <input type="checkbox"/> Excess sweating <input type="checkbox"/> Night sweats <input type="checkbox"/> Loss of weight <input type="checkbox"/> Night pain <input type="checkbox"/> Generalized pain <input type="checkbox"/> Nervousness <input type="checkbox"/> Convulsions <input type="checkbox"/> Loss of sleep	<p>Respiratory</p> <input type="checkbox"/> Asthma <input type="checkbox"/> Chronic cough <input type="checkbox"/> Spitting up phlegm <input type="checkbox"/> Spitting up blood <input type="checkbox"/> Difficulty breathing	<p>Skin</p> <input type="checkbox"/> Rashes/itching <input type="checkbox"/> Bruise easily <input type="checkbox"/> Dryness <input type="checkbox"/> Boils <input type="checkbox"/> Hives (allergies)
<p>Neurologic</p> <input type="checkbox"/> Dizziness <input type="checkbox"/> Fainting <input type="checkbox"/> Problem speaking <input type="checkbox"/> Problem swallowing <input type="checkbox"/> Blurred vision <input type="checkbox"/> Double vision <input type="checkbox"/> Nausea <input type="checkbox"/> Clumsiness <input type="checkbox"/> Numbness/Tingling	<p>Cardiovascular</p> <input type="checkbox"/> Bleeding disorder <input type="checkbox"/> High blood pressure <input type="checkbox"/> Chest pain <input type="checkbox"/> Stroke <input type="checkbox"/> Hardening of arteries <input type="checkbox"/> Varicose veins <input type="checkbox"/> Swelling of ankles <input type="checkbox"/> Poor circulation <input type="checkbox"/> Heart/blood disease <input type="checkbox"/> Angina	<p>Gastrointestinal</p> <input type="checkbox"/> Poor appetite <input type="checkbox"/> Indigestion <input type="checkbox"/> Excess hunger <input type="checkbox"/> Belching or gas <input type="checkbox"/> Vomiting <input type="checkbox"/> Pain over stomach <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Jaundice <input type="checkbox"/> Gall bladder trouble <input type="checkbox"/> Intestinal worms <input type="checkbox"/> Ulcer <input type="checkbox"/> Diabetes
<p>Muscles and Joints</p> <input type="checkbox"/> Sore/stiff neck <input type="checkbox"/> Mid back ache <input type="checkbox"/> Low back ache <input type="checkbox"/> Painful tailbone <input type="checkbox"/> Shoulder pain <input type="checkbox"/> Arm/forearm pain <input type="checkbox"/> Elbow pain <input type="checkbox"/> Wrist/hand pain <input type="checkbox"/> Hip pain <input type="checkbox"/> Knee pain <input type="checkbox"/> Ankle/foot trouble <input type="checkbox"/> Arthritis <input type="checkbox"/> Loss of Strength	<p>Genitourinary</p> <input type="checkbox"/> Trouble urinating <input type="checkbox"/> Blood in urine <input type="checkbox"/> Kidney infection <input type="checkbox"/> Bedwetting <input type="checkbox"/> Prostate trouble	<p>Have you ever had any fractures? <input type="checkbox"/> yes <input type="checkbox"/> no If yes, where? _____</p> <p>Have you ever been in a car accident? <input type="checkbox"/> yes <input type="checkbox"/> no If yes, when? _____</p> <p>Have you ever been hospitalized? <input type="checkbox"/> yes <input type="checkbox"/> no If yes, when/why? _____</p> <p>Are you currently a smoker? <input type="checkbox"/> yes <input type="checkbox"/> no How much? _____</p> <p>Did you smoke previously? <input type="checkbox"/> yes <input type="checkbox"/> no How much? _____</p>
<p>Eyes/Ears/Nose/Throat</p> <input type="checkbox"/> Failing vision <input type="checkbox"/> Eye pain <input type="checkbox"/> Failing hearing <input type="checkbox"/> Earache <input type="checkbox"/> Ring/buzz in ears <input type="checkbox"/> Frequent colds <input type="checkbox"/> Sinus infection <input type="checkbox"/> Enlarged thyroid <input type="checkbox"/> Enlarged glands	<p>GU for Women</p> <input type="checkbox"/> Painful menstruation <input type="checkbox"/> Excessive flow <input type="checkbox"/> Hot flashes <input type="checkbox"/> Irregular/absent cycle <input type="checkbox"/> Cramping/backache <input type="checkbox"/> Vaginal discharge <input type="checkbox"/> Swollen breasts <input type="checkbox"/> Lump in breasts	<p>Currently on birth control pills/patch? <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Previously on birth control pills/patch? <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p># of pregnancies: _____ children: _____</p>
<p>Medications (list):</p> 		
<p>Clinician Comments:</p> 		