Name: ______________________________

Date: __________________________

CONSTITUTIONAL SYMPTOMS

Good general health lately	NO	YES
Recent weight change	NO	YES
Fever	NO	YES
Fatigue	NO	YES
Headaches	NO	YES

EYES

Eye disease or injury	NO	YES
Blurred or double vision	NO	YES
Wear glasses/contact lenses	NO	YES
Glaucoma	NO	YES

EARS/NOSE/MOUTH/THROAT

Hearing loss or ringing	NO	YES
Earaches or draining	NO	YES
Chronic sinus problem or rhinitis	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

CARDIOVASCULAR

Heart trouble	NO	YES
Chest pain or angina pectoris	NO	YES
Palpitations	NO	YES
Shortness of breath while walking or lying	NO	YES

RESPIRATORY

Chronic or frequent cough	NO	YES
Spitting up blood	NO	YES
Shortness of breath	NO	YES
Asthma or wheezing	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
Rectal bleeding or blood in stool	NO	YES
Abdominal pain or heartburn	NO	YES
Peptic ulcer (stomach or duodenal)	NO	YES

GENITOURINARY

Frequent urination	NO	YES
Burning or painful urination	NO	YES
Blood in urine	NO	YES
Change in force or strain with urination	NO	YES
Incontinence or dribbling	NO	YES
Kidney stones	NO	YES
Sexual difficulty	NO	YES
Male-testicular pain	NO	YES
Female-pain with periods	NO	YES
-irregular periods	NO	YES
-vaginal discharge	NO	YES

#pregnancies______ miscarriages______

Date of last pap smear_________________

Date of last mammogram ______________

MUSCULOSKELETAL

Joint pain	NO	YES
Joint stiffness and swelling	NO	YES
Weakness of muscles or joints	NO	YES
Back pain	NO	YES
Cold extremities	NO	YES
Difficulty in walking	NO	YES

INTEGUMENTARY (skin, breasts)

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
History of skin cancer	NO	YES
Type______________________________		
Extensive sun exposure	NO	YES
Tanning bed use	NO	YES
Changing spots	NO	YES

NEUROLOGICAL

Frequent or recurring headaches	NO	YES
Lightheaded or dizzy	NO	YES
Convulsions or seizures	NO	YES
Numbness or tingling sensations	NO	YES
Tremors	NO	YES
Paralysis	NO	YES
Stroke	NO	YES
Head injury	NO	YES

PSYCHIATRIC

Memory loss or confusion	NO	YES
Nervousness	NO	YES
Depression	NO	YES
Insomnia	NO	YES

ENDOCRINE

Glandular or hormone problem	NO	YES
Thyroid disease	NO	YES
Diabetes	NO	YES
Excessive thirst or urination	NO	YES
Heat or cold intolerance	NO	YES
Skin becoming dryer	NO	YES
Change in hat or glove size	NO	YES

HEMATOLOGICAL/LYMPHATIC

Slow to heal after cuts	NO	YES
Bleeding or bruising tendency	NO	YES
Anemia	NO	YES
Phlebitis	NO	YES
Past transfusion	NO	YES
Enlarged glands	NO	YES

ALLERGIC/IMMUNOLOGIC

Any known allergies to medicine? List:

____

Any other known allergies? List:

____