Name: (Please print) _____ PLEASE SEE SECOND PAGE!

Select only one answer per question. Fill in bubble completely Example: ● Yes O No

GENERAL

Fever	O Yes	O No	Fatigue	O Yes	O No
Sweats	O Yes	O No	Change in Weight	O Yes	O No
Change in Appetite	O Yes	O No			

Head, Eyes, Ears, Nose, Throat

Hoarseness/voice change	O Yes	O No	hearing loss/ringing in ears	O Yes	O No
Teeth pain	O Yes	O No	Nosebleeds	O Yes	O No
Difficulty swallowing	O Yes	O No	bad taste or breath	O Yes	O No
Mouth sores	O Yes	O No	Snoring	O Yes	O No
vision changes	O Yes	O No	glasses and/or contacts	O Yes	O No

CARDIOLOGY

Chest pain	O Yes	O No	short of breath when lying flat	O Yes	O No
Pains in leg while walking	O Yes	O No	Irregular heart beat/palpitations	O Yes	O No
Difficulty walking up stairs	O Yes	O No			

RESPIRATORY

Shortness of breath	O Yes	O No	Chest congestion	O Yes	O No
Wheezing	O Yes	O No	Blood-tinged sputum	O Yes	O No
Pain with breathing	O Yes	O No			

GASTROENTEROLOGY

Nausea or Vomiting	O Yes	O No	Constipation	O Yes	O No
Diarrhea	O Yes	O No	rectal bleeding/blood in stool	O Yes	O No
Hemorrhoids	O Yes	O No	Bloating	O Yes	O No
Change in bowel habits	O Yes	O No	heartburn	O Yes	O No

MALE REPRODUCTIVE

sexual difficulty	O Yes	O No	Hernia	O Yes	O No
Testicular pain or swelling	O Yes	O No			

FEMALE REPRODUCTIVE

Abnormal vaginal discharge	O Yes	O No	Irregular Menses	O Yes	O No
Breast lumps or discharge	O Yes	O No	Breast tenderness	O Yes	O No
Breast tenderness	O Yes	O No	Contraception	O Yes	O No
Still Menstruating	O Yes	O No			

MUSCULOSKELETAL

Joint swelling	O Yes	O No	Joint stiffness	O Yes	O No
Joint pain	O Yes	O No	Muscle aches or weakness	O Yes	O No

SKIN

Healing problems	O Yes	O No	Changing moles	O Yes	O No
Rash or itching	O Yes	O No	Varicose Veins	O Yes	O No
Change in Hair or Nails	O Yes	O No			

NEUROLOGY

Tingling/numbness	O Yes	O No	Memory loss	O Yes	O No
Weakness	O Yes	O No	Tremor	O Yes	O No
Confusion	O Yes	O No	Trouble with balance	O Yes	O No
Frequent headaches	O Yes	O No			

ENDOCRINOLOGY

Excessive sweating	O Yes	O No	Excessive thirst or urination	O Yes	O No
Skin changes	O Yes	O No	Heat or cold intolerance	O Yes	O No

HEMATOLOGY/LYMPH

Swollen glands	O Yes	O No	Easy bleeding	O Yes	O No

UROLOGY

Blood in urine	O Yes	O No	Pain with urination	O Yes	O No
Urinary frequency	O Yes	O No	Urinary urgency	O Yes	O No

Please list any **NEW** DRUG, FOOR OR NON-FOOD Allergies that you have developed in the last year.

_____ _____ _____

_____ _____ _____

Please list any SURGERIES, MAJOR PROCEDURES, HOSPITALIZATIONS OR INJURIES in the last year

_____ _____ _____

_____ _____ _____