

Patient Name: _____ Date ____/____/____

Age _____ Birthday _____ Date of last physical examination _____

What is your reason for visit? _____

SYMPTOMS

Check () symptoms you currently have or have had in the past year.

GENERAL

- Chills
- Depression
- Dizziness
- Fainting
- Fever
- Forgetfulness
- Headache
- Loss of Sleep
- Loss of Weight
- Nervousness
- Sweats

EYES

- Crossed eyes
- Double vision
- Vision - Flashes
- Vision - Halos
- Blurred vision

EARS/NOSE/THROAT

- Earache
- Ear Discharge
- Ringing in ears
- Loss of hearing
- Hay fever
- Sinus problem
- Nose bleeds
- Bleeding gums
- Hoarseness
- Difficulty swallowing
- Persistent cough

RESPIRATORY

- Shortness of breath
- Cough Congestion
- Distress Sputum

GENITO-URINARY

- Blood in urine
- Frequent urination
- Lack of bladder control
- Painful urination

ENDOCRINE

- Weight gain
- Wight loss
- Hoarseness
- Heat Intolerance
- Cold Intolerance
- Breast Changes
- Hair C hanges
- Extreme Thirst

GASTROINTESTINAL

- Appetite poor
- Bloating
- Bowel changes
- Constipation
- Diarrhea
- Excessive hunger
- Excessive thirst
- Gas
- Hemorrhoids
- Indigestion
- Nausea
- Rectal bleeding
- Stomach pain
- Vomiting no blood
- Vomiting bleeding

CARDIOVASCULAR

- Chest pain
- High blood pressure
- Irregular heart beat
- Low blood pressure
- Poor circulation
- Rapid heart beat
- Swelling of ankles
- Varicose veins

WOMEN only

- Abnormal Pap Smear
- Bleeding between periods
- Breast lumps
- Extreme menstrual pain
- Hot flashes
- Nipples discharge
- Painful intercourse
- Vaginal discharge
- Other _____
- Date of last menstrual period _____

Date of last Pap Smear _____

Have you had a mammogram? _____

Are you pregnant? _____

Number of children _____

MEN only

- Breast lumps
- Erection difficulties
- Lump in testicles
- Penis discharge
- Sore on penis
- Other _____

INTEGUMENTARY

- Bruise easy
- Hives
- Change in moles
- Sores that wont heal
- Itching
- unusual swelling
- sores/ulcers
- Rash
- Scars

NEUROLOGICAL

- Seizures
- Vertigo
- Dizziness
- Hand Trembling
- Loss of Sensations
- Loss of facial epression
- Weak Grip
- Paralysis
- Difficulty of Speech
- Tingling
- Loss of Memory
- Numbness
- Un-coordination

MUSCLE/JOINT/BONE

- Arms
- Hips
- Back
- Legs
- Feet
- Neck
- Hands
- Shoulders

PSYCHIATRIC

- Hyperventilation
- Insecurity
- Depression
- Trouble Sleeping
- Irritable
- Anxiousness
- Undecidedness
- Timid
- Hallucinations
- Loss of Memory
- Alcoholism
- Drug Addiction
- Drug Dependency
- Extreme Worry
- Sexual Problems
- Suicidal Thoughts

CONDITIONS

- AIDS
- Alcoholism
- Anemia
- Anorexia
- Appendicitis
- Asthma
- Bleeding Disorders
- Breast Lumps
- Bronchitis
- Breath shortness
- Buliemia
- Cancer
- Cataracts
- Chemical Dependency
- Chicken Pox
- Diabetes
- Emphysema
- Epilepsy
- Glaucoma
- Goiter
- Gonorrhea
- Gout
- Heart Disease
- Hepatitis
- Hernia
- Herpes
- High Cholesterol
- HIV Positive
- Kidney Disease
- Liver Disease
- Measles
- Migraine Headaches
- Miscarriage
- Mononucleosis
- Multiple Sclerosis
- Mumps
- Pneumonia
- Polio
- Prostate Problem
- Psychiatric Care
- Rheumatic Fever
- Scarlet Fever
- Stroke
- Suicide Attempt
- Thyroid Fever
- Ulcers
- Vaginal Infections
- Venereal Disease
- Other _____

MEDICATIONS

List medications you are currently taking, and dosages

ALLERGIES to medications or substances

Patient Signature _____
(or guardian)

Date ____/____/____