NAME: DATE:

General Health: Please check any of the following symptoms that you have had recently

General	☐Fever	☐Chills	☐Sweats	☐Excessive Fatigue	☐Malaise	☐Weight Loss
Cardiovascular	☐ Chest Pain	☐ Palpitations	☐ Fainting	☐ Shortness of Breath	☐ Circulatory Problems (arms or legs)	
Endocrinological	☐ Cold or heat	intolerance	☐ excessive thirst or drinking			
ENT	☐ ear pain	☐ ringing in ear	☐ decreased hearing	☐ sore throat	☐ trouble swallowing	
Eyes	☐ Blurred vision	☐ double vision	☐visual loss	☐eye pain	☐light sensitivity	
GI	☐nausea	☐ Vomiting	☐diarrhea	☐constipation	☐abdominal pain	
GU/GYN	☐urinary incontinence	☐urinary retention	☐kidney stones	☐prostate problems	☐menstrual irregularities	
Hematological	☐abnormal bruising	☐ Bleeding	☐enlarged lymph nodes	☐anemia		
Mental Health	☐depression	☐anxiety	☐difficulty sleeping	☐hallucinatio ns		
Musculoskeletal	☐back pain	☐neck pain	☐joint pain	☐muscle cramps	☐arthritis	
Neurological	☐head injury	☐stroke	☐TIA	☐seizures		
Respiratory	☐Coughing	☐wheezing	☐bloody sputum	☐asthma	☐emphysema	
Skin	☐rash	☐itching	☐ Dryness			
Pacemaker	☐ YES	☐ NO	**Hearing Aid**	☐YES	☐NO	

NAME: DATE:

Past Medical Problems: Please check any that you have had and give dates if appropriate

Past Meidcal Problem	Yes	No
Asthma	☐	☐
Diabetes	☐	☐
Gastrointestinal Problems	☐	☐
Heart Disease	☐	☐
Hepatitis	☐	☐
High Blood Pressure	☐	☐
High Cholesterol	☐	☐
Osteoporosis	☐	☐
Thyroid Abnormalities	☐	☐
Tumors	☐	☐
Ulcers	☐	☐

Past Surgical Procedures

Year	**Procedure**	**Complications**

Family History. Please list any significant medical conditions that have occurred in your family. In particular, mention any history of stroke, Parkinson's disease, seizures, brain tumors, dememntia, migraines, multiple sclerosis, or other neurological conditions.

___

___

___

NAME: DATE:

Medications. Please list the medications you are currently taking (Remember, aspirin is a medication).

Allergies. Please list your allergies, including allergies to medications.