

NAME:

DATE:

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

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

NAME:

DATE:

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

Past Medical Problem	Yes	No
Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Gastrointestinal Problems	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Abnormalities	<input type="checkbox"/>	<input type="checkbox"/>
Tumors	<input type="checkbox"/>	<input type="checkbox"/>
Ulcers	<input type="checkbox"/>	<input type="checkbox"/>

**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, dementia, 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.

---

---

---

---

---