

Patient Name: _____ **DOB:** _____ **Visit Date:** _____ **Page 1 of 3**

Please mark YES or NO for any symptoms you have had within the last two weeks

General

Weight Loss: Yes No

Change in appetite: Yes No

Weight Gain: Yes No

Fatigue: Yes No

Fever: Yes No

Night Sweats: Yes No

Eyes

Pain: Yes No

Blurred vision: Yes No

Itching/Redness: Yes No

Dry eyes: Yes No

ENT

Congestion: Yes No

Nose Bleeds: Yes No

Sinus pain: Yes No

Post Nasal drip: Yes No

ringing in ears: Yes No

Ear pain: Yes No

Decreased hearing: Yes No

Sore Throat: Yes No

Swollen glands: Yes No

Endocrine

Change in Voice: Yes No

Heat Intolerance: Yes No

Cold Intolerance: Yes No

Breast Changes: Yes No

Loss of Hair: Yes No

Excessive Thirst: Yes No

Low Blood Sugar: Yes No

Respiratory

Phlegm (sputum production): Yes No

Shortness of Breath: Yes No

Cough: Yes No

Coughing up blood: Yes No

Wheezing: Yes No

Cardiovascular

Chest pain: Yes No

Swollen extremities: Yes No

Irregular Heartbeat: Yes No

Tightness/Pressure: Yes No

Gastrointestinal

Nausea: Yes No

Vomiting: Yes No

Abdominal pain: Yes No

Gas: Yes No

Bloating: Yes No

Heartburn: Yes No

Difficulty swallowing: Yes No

Change in bowel habits: Yes No

Constipation: Yes No

Diarrhea: Yes No

Blood in stool: Yes No

Hematologic

Easy Bruising: Yes No

Prolonged bleeding: Yes No

Recent blood transfusion: Yes No

Genitourinary

- Urgent urination: Yes No
- Burning w/ Urination: Yes No
- Blood in urine: Yes No
- Incontinence: Yes No
- Frequent urination: Yes No
- Frequent urination at night: Yes No

Neurologic

- Headaches: Yes No
- Dizziness: Yes No
- Loss of sensation: Yes No
- Trembling hands: Yes No
- Confusion: Yes No
- Slurred speech: Yes No
- Tingling/Numbness: Yes No
- Trouble Walking: Yes No
- Trouble with coordination: Yes No
- Memory loss: Yes No
- Lack of concentration: Yes No

Musculoskeletal

- Painful Joints: Yes No
- Swollen Joints: Yes No
- Leg Cramps: Yes No
- Back Pain: Yes No
- Weakness: Yes No

Psychiatric

- Anxiety: Yes No
- Depressed mood: Yes No
- Stressors: Yes No
- Difficulty sleeping: Yes No
- Suicidal thoughts: Yes No

Skin

- Nail Changes: Yes No
- Rash: Yes No
- Skin lesions: Yes No
- Dry: Yes No

Past Medical History

- GERD/Heartburn
- Ulcers
- Colon Polyps
- Hernia
- Pancreatitis
- Ulcerative Colitis
- Hypertension
- Coronary Artery Disease
- Anemia
- Congestive Heart Failure
- Atrial Fibrillation
- Pacemaker
- COPD
- Diabetes
- Thyroid Problems
- Elevated Cholesterol
- Stroke
- Kidney stones
- Fibromyalgia
- Arthritis
- Chronic Back pain
- Cancer
- Kidney Failure
- Heart Attack
- Seizures
- History of mental illness
- Depression
- Paralysis
- Migraine
- Gout
- Cataracts
- Glaucoma
- Prostate problems
- Asthma

Surgical History

- | | | |
|--|---|---|
| <input type="radio"/> Colonoscopy | <input type="radio"/> Heart Bypass Surgery | <input type="radio"/> Back Surgery |
| <input type="radio"/> EGD(Upper endoscopy) | <input type="radio"/> Heart Valve Replacement | <input type="radio"/> Hip Surgery |
| <input type="radio"/> Ulcer Surgery | <input type="radio"/> Hysterectomy | <input type="radio"/> Knee Surgery |
| <input type="radio"/> Colon Surgery | <input type="radio"/> Ovaries Removed | <input type="radio"/> Weight Loss Surgery |
| <input type="radio"/> Cholecystectomy | <input type="radio"/> Breast Cancer Surgery | <input type="radio"/> Eye Surgery |
| <input type="radio"/> Appendectomy | <input type="radio"/> Breast Surgery | |
| <input type="radio"/> Hemorrhoidectomy | <input type="radio"/> Prostate Surgery | |

Family History **Mark only those that apply or NONE**

- | | | | | | |
|---------------------------|------------------------------------|--|---|---|------------------------------|
| <u>Mother</u> | <input type="radio"/> Arthritis | <input type="radio"/> Heart Attack | <input type="radio"/> Heart Disease | <input type="radio"/> Peripheral Vascular Disease | |
| | <input type="radio"/> Hypertension | <input type="radio"/> High Cholesterol | <input type="radio"/> Diabetes Mellitus | <input type="radio"/> Stroke | <input type="radio"/> Cancer |
| <u>Father</u> | <input type="radio"/> Arthritis | <input type="radio"/> Heart Attack | <input type="radio"/> Heart Disease | <input type="radio"/> Peripheral Vascular Disease | |
| | <input type="radio"/> Hypertension | <input type="radio"/> High Cholesterol | <input type="radio"/> Diabetes Mellitus | <input type="radio"/> Stroke | <input type="radio"/> Cancer |
| <u>Siblings</u> | <input type="radio"/> Arthritis | <input type="radio"/> Heart Attack | <input type="radio"/> Heart Disease | <input type="radio"/> Peripheral Vascular Disease | |
| | <input type="radio"/> Hypertension | <input type="radio"/> High Cholesterol | <input type="radio"/> Diabetes Mellitus | <input type="radio"/> Stroke | <input type="radio"/> Cancer |
| <u>Grandparent</u> | <input type="radio"/> Arthritis | <input type="radio"/> Heart Attack | <input type="radio"/> Heart Disease | <input type="radio"/> Peripheral Vascular Disease | |
| | <input type="radio"/> Hypertension | <input type="radio"/> High Cholesterol | <input type="radio"/> Diabetes Mellitus | <input type="radio"/> Stroke | <input type="radio"/> Cancer |