PATIENT NAME: ________________________ DATE OF BIRTH:

HAVE YOU HAD ANY OF THE FOLLOWING DURING THE PAST ONE-YEAR?

- PLEASE ANSWER ALL QUESTIONS AND CIRCLE NO OR YES -

CONSTITUTIONAL		
Recent weight change	No	Yes
Fever	No	Yes
Night sweats or chills	No	Yes
Fatigue	No	Yes
Daytime drowsiness	No	Yes
Changes in sleep	No	Yes
EYES		
Eye disease	No	Yes
Glaucoma	No	Yes
ENT		
Sinus problems	No	Yes
Persistent hoarseness	No	Yes
Post-nasal drip	No	Yes
Runny nose	No	Yes
Seasonal allergies	No	Yes
Broken nose	No	Yes
CARDIOVASCULAR		
Heart problems	No	Yes
Chest pain	No	Yes
Heart murmur	No	Yes
Swelling feet or ankles	No	Yes
Blood clots	No	Yes
Rheumatic fever	No	Yes
RESPIRATORY		
Frequent cough	No	Yes
Sputum production	No	Yes
Spitting up blood	No	Yes
Shortness of breath	No	Yes
Asthma or wheezing	No	Yes
History of tuberculosis	No	Yes
GASTROINTESTINAL		
Loss of appetite	No	Yes
Stomach ulcers	No	Yes
Gastric reflux / heartburn	No	Yes
Liver problems / hepatitis	No	Yes

GENITOURINARY		
Burning or painful urination	No	Yes
Kidney problems	No	Yes
Blood in urine	No	Yes
Frequent urinary infections	No	Yes
MUSCULOSKELETAL		
Joint stiffness or swelling	No	Yes
Weakness of muscles	No	Yes
Difficulty walking	No	Yes
SKIN		
Rash	No	Yes
Persistent itching	No	Yes
NEUROLOGICAL		
Frequent headaches	No	Yes
Convulsions or seizures	No	Yes
Tremors	No	Yes
Stroke	No	Yes
PSYCHIATRIC		
Memory loss or confusion	No	Yes
Depression	No	Yes
Anxiety	No	Yes
ENDOCRINE		
Thyroid disease	No	Yes
Diabetes	No	Yes
HEMATOLOIGIC/LYMPHATIC		
Easily bruising or bleeding	No	Yes
Anemia	No	Yes
ALLERGIC/IMMUNOLOGIC		
Medication allergies	No	Yes
Food allergies	No	Yes

Patient Signature: ____________________

Physician Signature: ____________________
Date: ________________________________
(Date by physician only)