PATIENT NAME: _____ **DATE OF BIRTH:** _____

Western Washington Medical Group

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

- PLEASE ANSWER ALL QUESTIONS AND CHECK 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: _____