

Please fill in circles below

Patient Name _____ Date of Birth _____

Do you use any Tobacco? current smoker nonsmoker

Do you use alcohol? Yes No Socially Recovering

Have you used recreational drugs? Yes No

Caffeine intake? Yes No

Do you exercise regularly? Yes No

Marital Status:

Are you currently Single Married Divorced Widowed

Family History:

Status A=Alive D=Deceased



Father: A D Cancer Diabetes Mental Illness Hypertension

Heart Disease Stroke Unknown

Mother: A D Cancer Diabetes Mental Illness Hypertension

Heart Disease Stroke Unknown

Children: A D Cancer Diabetes Mental Illness Hypertension

Heart Disease Stroke Unknown

Siblings: A D Cancer Diabetes Mental Illness Hypertension

Heart Disease Stroke Unknown

Past Medical History

High Blood Pressure Heart Attack Diabetes Asthma Thyroid Disorder

Stroke Cancer

Current Medical Problem

High Blood Pressure Coronary Artery Disease Diabetes Asthma

Thyroid Disorder Congestive Heart Failure COPD GERD

Patient Name: _____ Date of Birth: _____

General

| | | |
|------------------|---------------------------|--------------------------|
| Fever | <input type="radio"/> Yes | <input type="radio"/> No |
| Chills | <input type="radio"/> Yes | <input type="radio"/> No |
| Night sweats | <input type="radio"/> Yes | <input type="radio"/> No |
| Fatigue | <input type="radio"/> Yes | <input type="radio"/> No |
| Weakness | <input type="radio"/> Yes | <input type="radio"/> No |
| Change in Weight | <input type="radio"/> Yes | <input type="radio"/> No |

Eyes

| | | |
|-----------------------|---------------------------|--------------------------|
| Eye irritation | <input type="radio"/> Yes | <input type="radio"/> No |
| Seasonal eye symptoms | <input type="radio"/> Yes | <input type="radio"/> No |
| Change in vision | <input type="radio"/> Yes | <input type="radio"/> No |
| Cataracts | <input type="radio"/> Yes | <input type="radio"/> No |
| Glaucoma | <input type="radio"/> Yes | <input type="radio"/> No |

Ear, Nose, Throat

| | | |
|-------------------------------------|---------------------------|--------------------------|
| Ear Symptoms | <input type="radio"/> Yes | <input type="radio"/> No |
| Sinus Problems | <input type="radio"/> Yes | <input type="radio"/> No |
| Frequent nosebleed | <input type="radio"/> Yes | <input type="radio"/> No |
| Change in Hearing | <input type="radio"/> Yes | <input type="radio"/> No |
| Sore throat / Difficulty Swallowing | <input type="radio"/> Yes | <input type="radio"/> No |
| Change in Voice | <input type="radio"/> Yes | <input type="radio"/> No |

Cardiovascular

| | | |
|------------------------|---------------------------|--------------------------|
| Chest pain | <input type="radio"/> Yes | <input type="radio"/> No |
| Palpitations | <input type="radio"/> Yes | <input type="radio"/> No |
| High blood pressure | <input type="radio"/> Yes | <input type="radio"/> No |
| Swelling of hands/feet | <input type="radio"/> Yes | <input type="radio"/> No |

Respiratory

| | | |
|---------------------|---------------------------|--------------------------|
| Shortness of breath | <input type="radio"/> Yes | <input type="radio"/> No |
| Cough | <input type="radio"/> Yes | <input type="radio"/> No |
| Blood-tinged sputum | <input type="radio"/> Yes | <input type="radio"/> No |

Gastrointestinal

| | | |
|-------------------------|---------------------------|--------------------------|
| Nausea / Vomiting | <input type="radio"/> Yes | <input type="radio"/> No |
| Abdominal pain | <input type="radio"/> Yes | <input type="radio"/> No |
| Heartburn / Indigestion | <input type="radio"/> Yes | <input type="radio"/> No |
| Change in Appetite | <input type="radio"/> Yes | <input type="radio"/> No |
| Change in bowels | <input type="radio"/> Yes | <input type="radio"/> No |

Musculoskeletal

| | | |
|------------------------|---------------------------|--------------------------|
| Muscle Pain / Cramping | <input type="radio"/> Yes | <input type="radio"/> No |
| Joint stiffness | <input type="radio"/> Yes | <input type="radio"/> No |
| Joint swelling | <input type="radio"/> Yes | <input type="radio"/> No |
| Joint pain | <input type="radio"/> Yes | <input type="radio"/> No |

Neurological

| | | |
|----------------------|---------------------------|--------------------------|
| Tremors / Paralysis | <input type="radio"/> Yes | <input type="radio"/> No |
| Seizures / Strokes | <input type="radio"/> Yes | <input type="radio"/> No |
| Tingling / Numbness | <input type="radio"/> Yes | <input type="radio"/> No |
| Trouble with balance | <input type="radio"/> Yes | <input type="radio"/> No |

Skin

| | | |
|--------------------------|---------------------------|--------------------------|
| Change in hair/nails | <input type="radio"/> Yes | <input type="radio"/> No |
| Suspicious lesions/moles | <input type="radio"/> Yes | <input type="radio"/> No |
| Rash/Itching | <input type="radio"/> Yes | <input type="radio"/> No |
| Healing problems | <input type="radio"/> Yes | <input type="radio"/> No |

Endocrine

| | | |
|--------------------------|---------------------------|--------------------------|
| Excessive thirst | <input type="radio"/> Yes | <input type="radio"/> No |
| Thyroid disorder | <input type="radio"/> Yes | <input type="radio"/> No |
| Abnormal Breast Problems | <input type="radio"/> Yes | <input type="radio"/> No |

Hematologic / Lymphatic

| | | |
|----------------|---------------------------|--------------------------|
| Easy bruising | <input type="radio"/> Yes | <input type="radio"/> No |
| Easy bleeding | <input type="radio"/> Yes | <input type="radio"/> No |
| Swollen glands | <input type="radio"/> Yes | <input type="radio"/> No |
| Slow healing | <input type="radio"/> Yes | <input type="radio"/> No |

Urology

| | | |
|----------------------|---------------------------|--------------------------|
| Urinary incontinence | <input type="radio"/> Yes | <input type="radio"/> No |
| Urinary frequency | <input type="radio"/> Yes | <input type="radio"/> No |
| Pain with urination | <input type="radio"/> Yes | <input type="radio"/> No |
| Blood in urine | <input type="radio"/> Yes | <input type="radio"/> No |
| Kidney disease | <input type="radio"/> Yes | <input type="radio"/> No |

Psychiatric

| | | |
|----------------|---------------------------|--------------------------|
| Anxiety | <input type="radio"/> Yes | <input type="radio"/> No |
| Depression | <input type="radio"/> Yes | <input type="radio"/> No |
| Memory loss | <input type="radio"/> Yes | <input type="radio"/> No |
| Mental Illness | <input type="radio"/> Yes | <input type="radio"/> No |

Male - Only

| | | |
|-----------------------------|---------------------------|--------------------------|
| Hernia | <input type="radio"/> Yes | <input type="radio"/> No |
| Testicular pain or swelling | <input type="radio"/> Yes | <input type="radio"/> No |
| Sexual Problems | <input type="radio"/> Yes | <input type="radio"/> No |

Female - Only

| | | |
|--------------------|---------------------------|--------------------------|
| Pelvic pain | <input type="radio"/> Yes | <input type="radio"/> No |
| Menstrual Problems | <input type="radio"/> Yes | <input type="radio"/> No |
| Sexual Problems | <input type="radio"/> Yes | <input type="radio"/> No |