

SYSTEMS/SYMPTOMS

Check conditions you currently have or have had in the past

<p><u>General</u></p> <ul style="list-style-type: none"><input type="checkbox"/> Fever/Chills<input type="checkbox"/> Fatigue<input type="checkbox"/> Sleep problems<input type="checkbox"/> Depression<input type="checkbox"/> Dizziness<input type="checkbox"/> Fainting<input type="checkbox"/> Headache<input type="checkbox"/> Nervousness<input type="checkbox"/> Numbness<input type="checkbox"/> Cancer<input type="checkbox"/> Alcoholism <p><u>Respiratory</u></p> <ul style="list-style-type: none"><input type="checkbox"/> Short of breath<input type="checkbox"/> Cough<input type="checkbox"/> Asthma<input type="checkbox"/> Recurrent pneumonia<input type="checkbox"/> Bronchitis<input type="checkbox"/> Emphysema<input type="checkbox"/> Sleep Apnea <p><u>Derm</u></p> <ul style="list-style-type: none"><input type="checkbox"/> Rash<input type="checkbox"/> Itching<input type="checkbox"/> Hives<input type="checkbox"/> Change in moles<input type="checkbox"/> Sore that will not heal<input type="checkbox"/> Bruise easily	<p><u>Eyes</u></p> <ul style="list-style-type: none"><input type="checkbox"/> Blurry vision<input type="checkbox"/> Double vision<input type="checkbox"/> Loss of vision-R<input type="checkbox"/> Loss of vision-L<input type="checkbox"/> Glaucoma <p><u>ENT</u></p> <ul style="list-style-type: none"><input type="checkbox"/> Decreased hearing<input type="checkbox"/> Sore throat<input type="checkbox"/> Ears ringing<input type="checkbox"/> Bleeding gums<input type="checkbox"/> Hay Fever<input type="checkbox"/> Persistent cough<input type="checkbox"/> Sinus problems <p><u>Psych</u></p> <ul style="list-style-type: none"><input type="checkbox"/> Anxiety<input type="checkbox"/> Depression<input type="checkbox"/> Suicide Attempts <p><u>Endo</u></p> <ul style="list-style-type: none"><input type="checkbox"/> Weight change<input type="checkbox"/> Thirsty all of the time<input type="checkbox"/> Diabetes<input type="checkbox"/> Goiter<input type="checkbox"/> Thyroid problem	<p><u>Cardiovascular</u></p> <ul style="list-style-type: none"><input type="checkbox"/> Chest pain<input type="checkbox"/> Fainting<input type="checkbox"/> High blood pressure<input type="checkbox"/> Low blood pressure<input type="checkbox"/> Poor circulation<input type="checkbox"/> Swelling of ankles<input type="checkbox"/> Varicose veins<input type="checkbox"/> Heart disease<input type="checkbox"/> High cholesterol<input type="checkbox"/> Pacemaker <p><u>Genital Urinary</u></p> <ul style="list-style-type: none"><input type="checkbox"/> Pain during urination<input type="checkbox"/> Incontinence<input type="checkbox"/> Increased frequency<input type="checkbox"/> Kidney disease <p><u>Neuro</u></p> <ul style="list-style-type: none"><input type="checkbox"/> Numbness<input type="checkbox"/> Tingling<input type="checkbox"/> Loss of balance<input type="checkbox"/> History of seizures<input type="checkbox"/> Epilepsy<input type="checkbox"/> Migraine headaches<input type="checkbox"/> Multiple sclerosis<input type="checkbox"/> Polio<input type="checkbox"/> Stroke	<p><u>GI</u></p> <ul style="list-style-type: none"><input type="checkbox"/> Heartburn<input type="checkbox"/> Constipation<input type="checkbox"/> Nausea<input type="checkbox"/> Vomiting<input type="checkbox"/> Diarrhea<input type="checkbox"/> Excessive thirst<input type="checkbox"/> Rectal bleeding<input type="checkbox"/> Liver disease<input type="checkbox"/> Hernia<input type="checkbox"/> Stomach pain<input type="checkbox"/> Hepatitis<input type="checkbox"/> Ulcer <p><u>ID</u></p> <ul style="list-style-type: none"><input type="checkbox"/> Aids/HIV<input type="checkbox"/> Chicken pox<input type="checkbox"/> Herpes<input type="checkbox"/> Measles<input type="checkbox"/> Mononucleosis<input type="checkbox"/> Rheumatic fever<input type="checkbox"/> Scarlet fever<input type="checkbox"/> Tuberculosis<input type="checkbox"/> Typhoid fever<input type="checkbox"/> Hepatitis	<p><u>Musculoskeletal</u></p> <ul style="list-style-type: none"><input type="checkbox"/> Joint swelling<input type="checkbox"/> Cramps<input type="checkbox"/> Weakness in arms<input type="checkbox"/> Weakness in back<input type="checkbox"/> Weakness in feet<input type="checkbox"/> Weakness in hands<input type="checkbox"/> Weakness in hips<input type="checkbox"/> Weakness in legs<input type="checkbox"/> Weakness in neck<input type="checkbox"/> Weakness in shoulders<input type="checkbox"/> Weakness in knees<input type="checkbox"/> Pain in arms<input type="checkbox"/> Pain in back<input type="checkbox"/> Pain in feet<input type="checkbox"/> Pain in hands<input type="checkbox"/> Pain in hips<input type="checkbox"/> Pain in legs<input type="checkbox"/> Pain in neck<input type="checkbox"/> Pain in shoulder<input type="checkbox"/> Pain in knees<input type="checkbox"/> Arthritis <p><u>Heme</u></p> <ul style="list-style-type: none"><input type="checkbox"/> Easy bruising<input type="checkbox"/> Bleeding<input type="checkbox"/> Enlarged lymph nodes<input type="checkbox"/> Anemia<input type="checkbox"/> Bleeding disorders
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SOCIAL HISTORY

Work in the home Retired Student Highest grade level completed _____
Currently Employed (Occupation _____) Currently off work (length of time _____)

Single Married Divorced Separated Widowed
Children? No Yes # _____

Do you live alone? No Yes

Exercise? Daily Weekly Monthly Rarely/Never

What type of exercise _____

History of substance abuse No Yes If yes, what? _____

Smoke currently? No Yes _____ Packs per day for _____ years.

Quit smoking? Year quit _____

Drink alcohol? No Daily 1-2 times/week 1-2 times/mo. 1-2 times/year

Weight _____ Height _____

SIGNATURES

Patient Signature: _____ Date: _____