Patient name _____ Date of Birth _____

I. REASON FOR YOUR VISIT: _____

II. HAVE YOU HAD ANY OF THE FOLLOWING SYMPTOMS RECENTLY, PLEASE CHECK (✓):

(✓)

1. CONSTITUTIONAL
_____ Weight loss / gain
_____ Fevers / chills
_____ Night sweats
_____ Fatigue

2. EYES
_____ Yellowing of eyes
_____ Dry eyes
_____ Eye redness / pain

3. EARS / NOSE / MOUTH / THROAT
_____ Sinus congestion
_____ Runny nose
_____ Sore throat
_____ Dry mouth
_____ Hoarseness
_____ Mouth sores / ulcers

4. RESPIRATORY
_____ Shortness of breath
_____ Cough
_____ Sputum production
_____ Spitting up blood
_____ Wheezing
_____ Pain with deep breath

5. CARDIOVASCULAR
_____ Chest pain
_____ Palpitations
_____ Swelling of ankles

6. HEMATOLOGICAL
_____ Bleeding or easy bruising
_____ Swollen glands

7. SKIN
_____ Rash
_____ Itching
_____ Hair loss
_____ Yellow jaundice

8. ENDOCRINE
_____ Heat or cold intolerance
_____ Excessive thirst / urination

(✓)

9. GASTROINTESTINAL
_____ Food sticking with swallowing
_____ Choking with swallowing
_____ Painful swallowing
_____ Heartburn / acid indigestion
_____ Poor appetite
_____ Feel full easily with eating
_____ Nausea
_____ Vomiting
_____ Abdominal pain or discomfort
_____ Bloating
_____ Excessive gas
_____ Diarrhea
_____ Constipation
_____ Recent change in bowel habits
_____ Black stool
_____ Red blood with bowel movement
_____ Unable to control stool

10. GENITOURINARY
_____ Painful urination
_____ Blood in urine
_____ Ulcers in genital area
_____ Straining to urinate
_____ Unable to control urine

11. MUSCULOSKELETAL
_____ Muscle aches / pains
_____ Joint aches / pains
_____ Red / hot / swollen joints
_____ Leg / arm swelling

12. PSYCHIATRIC
_____ Change in mood
_____ Memory loss or confusion
_____ Depression / anxiety
_____ Under psychiatric care

13. NEUROLOGICAL
_____ Headaches
_____ Dizziness
_____ Numbness / tingling
_____ Muscle weakness
_____ Light-headed with standing

III. ALLERGIES (MEDICATIONS, CONTRAST DYE OR LATEX)

_____

_____

PLEASE LIST ALL CURRENT MEDICATIONS ON OTHER SIDE INCLUDING SUPPLEMENTS AND OVER-THE-COUNTER MEDICATIONS

M.D. Reviewer Initials _____ Date _____/_____/_____

Medication/Supplement/Vitamins	Strength	How Often Taken