

(circle one)

Name _____

Date _____

Account # _____

DOB _____

Provider # _____

Do you have any of the following symptoms at this time?

GENERAL

Recent weight change YES NO

Weakness YES NO

Fatigue YES NO

Fever YES NO

Night Sweats YES NO

Chills YES NO

Cold/Flu YES NO

Headaches YES NO

EYES, EARS, NOSE AND ORAL CAVITY

Glasses or Contacts YES NO

Double Vision YES NO

Blurred Vision YES NO

Decreased Hearing YES NO

Hearing Aids YES NO

Ringing in Ears YES NO

Room Spinning (vertigo) YES NO

Nose Bleeds YES NO

Sinus Trouble YES NO

Loose Teeth YES NO

Dentures YES NO

Bleeding Gums YES NO

Frequent Sore Throat YES NO

NECK

Swollen Glands YES NO

Pain YES NO

PSYCHOSOCIAL

Anxiety YES NO

Depression YES NO

Suicidal/Homicidal YES NO

BREASTS

Lumps YES NO

Pain YES NO

RESPIRATORY

Chronic/Frequent Cough YES NO

Wheezing YES NO

Difficulty YES NO

CARDIAC

Heart Murmur YES NO

Palpitations YES NO

Chest Pain (angina) YES NO

Difficulty Lying Flat YES NO

GASTROINTESTINAL

Loss of appetite YES NO

Trouble swallowing YES NO

Nausea YES NO

Vomiting YES NO

Indigestion YES NO

Constipation YES NO

Diarrhea YES NO

Abdominal Pain YES NO

URINARY AND REPRODUCTIVE

Loss of bladder control YES NO

Freq Bladder Infections YES NO

Irregular Menstrual Cycle YES NO

SKIN

Rash YES NO

Lesions YES NO

Eruptions YES NO

MUSCULOSKELETAL

Joint Pain or Stiffness YES NO

Red or Warm Joints YES NO

Muscle Pain or Cramps YES NO

NERVES, ARTERIES, VEINS

Fainting YES NO

Seizures YES NO

Numbness/Tingling YES NO

Leg Pain w/Walking YES NO

BLOOD Easy to Bruise or Bleed YES NO

PHYSICIAN INITIALS & DATE

Patient Signature

Date

