

SYMPTOMS

***** Check symptoms you currently have or have had in the past*****

<p style="text-align: center;">GENERAL</p> <input type="checkbox"/> Chills <input type="checkbox"/> Depression <input type="checkbox"/> Dizziness <input type="checkbox"/> Fainting <input type="checkbox"/> Fever <input type="checkbox"/> Forgetfulness <input type="checkbox"/> Headaches <input type="checkbox"/> Loss of Sleep <input type="checkbox"/> Loss of weight <input type="checkbox"/> Nervousness <input type="checkbox"/> Numbness <input type="checkbox"/> Sweats	<p style="text-align: center;">GASTROINTESTINAL</p> <input type="checkbox"/> Poor appetite <input type="checkbox"/> Bloating <input type="checkbox"/> Bowel changes <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Excessive hunger <input type="checkbox"/> Excessive thirst <input type="checkbox"/> Gas <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Indigestion <input type="checkbox"/> Nausea <input type="checkbox"/> Rectal bleeding <input type="checkbox"/> Stomach pain <input type="checkbox"/> Vomiting <input type="checkbox"/> Vomiting blood	<p style="text-align: center;">EENT</p> <input type="checkbox"/> Bleeding gums <input type="checkbox"/> Blurred vision <input type="checkbox"/> Crossed eyes <input type="checkbox"/> Difficulty swallowing <input type="checkbox"/> Double vision <input type="checkbox"/> Earache <input type="checkbox"/> Ear discharge <input type="checkbox"/> Hay fever <input type="checkbox"/> Hoarseness <input type="checkbox"/> Loss of hearing <input type="checkbox"/> Nosebleed <input type="checkbox"/> Persistent cough <input type="checkbox"/> Ringing in ears <input type="checkbox"/> Sinus problems <input type="checkbox"/> Vision - Flashes	<p style="text-align: center;">MEN ONLY</p> <input type="checkbox"/> Breast Lump <input type="checkbox"/> Erection difficulties <input type="checkbox"/> Lump in testicles <input type="checkbox"/> Penis discharge <input type="checkbox"/> Sore on Penis <input type="checkbox"/> Other
<p style="text-align: center;">CARDIOVASCULAR</p> <input type="checkbox"/> Chest pain <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Irregular heart beat <input type="checkbox"/> Low Blood Pressure <input type="checkbox"/> Poor circulation <input type="checkbox"/> Rapid heart beat <input type="checkbox"/> Swelling of ankles <input type="checkbox"/> Varicose veins	<p style="text-align: center;">GENITO-URINARY</p> <input type="checkbox"/> Blood in urine <input type="checkbox"/> Frequent urination <input type="checkbox"/> Lack of bladder control <input type="checkbox"/> Painful urination	<p style="text-align: center;">SKIN</p> <input type="checkbox"/> Bruises easily <input type="checkbox"/> Hives <input type="checkbox"/> Itching <input type="checkbox"/> Changes in mole <input type="checkbox"/> Rash <input type="checkbox"/> Scars <input type="checkbox"/> Sores that won't heal	<p style="text-align: center;">WOMEN ONLY</p> <input type="checkbox"/> Abnormal pap smear <input type="checkbox"/> Bleeding between periods <input type="checkbox"/> Breast lump <input type="checkbox"/> Extreme Menstrual pain <input type="checkbox"/> Hot Flashes <input type="checkbox"/> Nipple discharge <input type="checkbox"/> Painful intercourse <input type="checkbox"/> Vaginal discharge <input type="checkbox"/> Other
<p style="text-align: center;">MUSCLE, JOINT & BONE</p> <p>Pain, weakness, numbness in</p> <input type="checkbox"/> Arms <input type="checkbox"/> Hips <input type="checkbox"/> Back <input type="checkbox"/> Legs <input type="checkbox"/> Feet <input type="checkbox"/> Neck <input type="checkbox"/> Hands <input type="checkbox"/> Shoulders			

Dates of Last:
 Menstrual Period: _____
 Pap Smear: _____
 Mammogram: _____
 Are you Pregnant? **Y / N**
 Number of children: _____

CONDITIONS

*** Check conditions that you currently have or have had in the past year. ***

<input type="checkbox"/> AIDS	<input type="checkbox"/> Chemical dependency	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Prostate problem
<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> HIV Positive	<input type="checkbox"/> Psychiatric care
<input type="checkbox"/> Anemia	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Rheumatic fever
<input type="checkbox"/> Anorexia	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Scarlet fever
<input type="checkbox"/> Appendicitis	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Measles	<input type="checkbox"/> Stroke
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Migraine headache	<input type="checkbox"/> Suicide attempt
<input type="checkbox"/> Asthma	<input type="checkbox"/> Goiter	<input type="checkbox"/> Miscarriage	<input type="checkbox"/> Thyroid problems
<input type="checkbox"/> Bleeding disorder	<input type="checkbox"/> Gonorrhea	<input type="checkbox"/> Mononucleosis	<input type="checkbox"/> Tonsillitis
<input type="checkbox"/> Breast Lump	<input type="checkbox"/> Gout	<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Mumps	<input type="checkbox"/> Typhoid fever
<input type="checkbox"/> Bulimia	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Cancer	<input type="checkbox"/> Hernia	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Vaginal infections
<input type="checkbox"/> Cataract	<input type="checkbox"/> Herpes	<input type="checkbox"/> Polio	<input type="checkbox"/> Venereal Disease

Patint Name: _____ **Birthdate:** _____
Date of last Physical: _____ **Allergies:** _____