Place a check by any of the conditions that apply to you. If there have not been any changes since your last visit check here: _____

Patient Name: _____ **Date: _____**

Constitutional

____Night Sweats
____Anorexia
____Chills
____Diaphoresis
____Recent Illness
____Fatigue
____Fever
____Insomnia
____Malaise
____Weight Gain/Obesity
____Weight Loss

Eyes

____Blindness
____Vision Change
____Visual Disturbance
____Amblyopia
____Cataract
____Diabetic Retinopathy
____Glaucoma
____Macular Degeneration

Ears/Nose/Throat/Neck

____Cancer of Head and Neck
____Dental Pain
____Gastroesophageal Reflux
____Nasal Allergies
____Sleep Apnea-Obstruction
____Sleep Disordered Breathing
____Snoring

Cardiovascular

____Arrhythmia
____Chest Pain/Pressure
____Claudication
____Dyspnea
____Edema
____Exercise Intolerance
____Fatigue
____Hypertension
____Near-Syncope/Dizziness
____Palpitations
____Syncope

Respiratory

____Asthma
____Productive Sputum
____Apneic Events
____Chest Congestion
____Chest Tightness
____Cigarette Smoking
____Cough
____Dyspnea on exertion
____Dyspnea
____Foul Smelling Sputum
____Hemoptysis
____Occupational Exposure
____Passive Smoking

Gastrointestinal

____Hemorrhoids
____Hepatitis
____Abdominal Pain
____Anorexia
____Constipation
____Diarrhea
____Dysphagia

Gastrointestinal (continued)

____Gastroesophageal Reflux
____Jaundice
____Melena
____Vomiting

Musculoskeletal

____Stiffness
____Swelling
____Arthralgia(s)
____Back Pain
____Bone Fracture
____Carpal Tunnel Syndrome
____Joint Complaint
____Muscle Weakness
____Myalgias
____Neck Pain
____Osteoporosis
____Sciatica
____Shoulder Pain

Dermatologic

____Rash
____Sores
____Acne Vulgaris
____Arthropod Bite
____Callus
____Cellulitis
____Ecchymosis
____Herpes Simplex
____Keloid
____Lupus Erythematosus
____Melanoma
____Neoplasm
____Pyogenic Granuloma
____Skin Cancer

Neurologic

____Dizziness
____Dyskinesia or Tremor
____Gait Abnormality
____Headache
____Back Pain
____Facial Pain
____Generalized Pain
____Limb Pain
____Neck Pain
____Paresis
____Paresthesia
____Seizure
____Spasms/Spasticity
____Syncope
____Vertigo

Psychiatric

____Alcohol Abuse
____Anxiety
____Conversion/Dissociative Phenom
____Depression
____Disturbances of Consciousness
____Disturbances of Emotion
____Disturbances of Memory
____Disturbances of Thinking
____Drug Abuse
____Eating Disorder
____Hallucination
____Mania

Psychiatric (continued)

____Psychosis
____Suicidality

Endocrine

____Diabetes Mellitus Type 1
____Diabetes Mellitus Type 2
____Adrenal Excess
____Adrenal Insufficiency
____Hypercalcemia
____Hyperglycemia
____Hyperlipidemia
____Hyperthyroidism
____Hypocalcemia
____Hypothyroid
____Obesity
____Pheochromocytoma
____Secondary amenorrhea
____Oligomenorrhea
____Chills

Hematologic/Lymphatic

____Abnormal Ecchymoses
____Petechiae
____Abnormal Bleeding
____Bruising
____Anemia
____Arterial Thrombosis
____Leukocytosis
____Leukopenia
____Lymph Node Enlargement/Mass
____Neutropenia
____Prolonged Bleeding Time
____Prolonged PT (INR)
____Pulmonary Embolus
____Thrombocytopenia
____Thrombocytosis
____Venous Thrombosis

Allergy/Immunology

____Anaphylactoid Reaction
____Angioedema
____Food Allergy (What Kind?)
____Rhinitis
____Urticaria

Medications

Are you taking any new medications? Yes or No
Please List _____

Have you discontinued any medications? Yes or No
Please List

_____

Have you changed any medications? Yes or NO
Please List

_____