Patient name: ___________________________________ Today's Date: _________________

In the past 6 months, have you experienced any of the following:

GENERAL

Fatigue	O Yes	O No
Change in Appetite	O Yes	O No
Chills	O Yes	O No
Feeling weak	O Yes	O No
Change Energy level	O Yes	O No
Change in Sleep Patterns	O Yes	O No

ENT

Change in Hearing	O Yes	O No
Sore throat	O Yes	O No
Frequent nosebleed	O Yes	O No
Sinus pain	O Yes	O No

EYE

Change in Vision	O Yes	O No

CARDIOLOGY

Shortness of Breath while Lying Flat	O Yes	O No
Pains in leg while walking	O Yes	O No
Swelling of ankles	O Yes	O No
Irregular heart beat	O Yes	O No
Chest Pain / Pressure	O Yes	O No

RESPIRATORY

Shortness of breath	O Yes	O No
Cough	O Yes	O No
Blood-Tinged Phlegm	O Yes	O No
Wheezing	O Yes	O No
Snoring	O Yes	O No
Chest congestion	O Yes	O No

GASTROENTEROLOGY

Diarrhea	O Yes	O No
Vomiting	O Yes	O No
Constipation	O Yes	O No
Nausea	O Yes	O No
Abdominal pain	O Yes	O No
Change in bowel habits	O Yes	O No
Blood in stool	O Yes	O No
Heartburn / Indigestion	O Yes	O No
Bloating / Gassy	O Yes	O No

 IN ORDER TO SCAN THIS INFORMATION INTO YOUR MEDICAL RECORD, WE NEED YOU TO FILL IN THE CIRCLES COMPLETELY. THANKS

Patient name: ______________________________ Today's Date: ______________

NEUROLOGY

Headache / Migraine	O Yes	O No
Tingling/numbness	O Yes	O No
Seizures / Convulsions	O Yes	O No
Memory loss	O Yes	O No
Dizziness	O Yes	O No
Tremor	O Yes	O No
Fainting	O Yes	O No
Trouble w/ Balance and/or Coordination	O Yes	O No
Loss of Smell / Taste	O Yes	O No

HEMATOLOGY/LYMPH

Swollen glands	O Yes	O No
Easy bruising	O Yes	O No
Easy bleeding	O Yes	O No

UROLOGY

Blood in urine	O Yes	O No
Difficulty urinating	O Yes	O No
Burning / Pain w/Urination	O Yes	O No
Urinary frequency	O Yes	O No
Urinary incontinence	O Yes	O No

SKIN

Concerning Moles	O Yes	O No
Concerning Lumps	O Yes	O No
Dry / Itchy	O Yes	O No

ENDOCRINOLOGY

Cold intolerance	O Yes	O No
Heat intolerance	O Yes	O No
Excessive thirst	O Yes	O No

MUSCULOSKELETAL

Joint pain	O Yes	O No
Joint swelling	O Yes	O No

MENTAL HEALTH

Anxiety	O Yes	O No
Suicidal Thoughts	O Yes	O No
High stress level	O Yes	O No
Mood swings	O Yes	O No
Poor Concentration	O Yes	O No
Depression	O Yes	O No

 IN ORDER TO SCAN THIS INFORMATION INTO YOUR MEDICAL RECORD, WE NEED YOU TO FILL IN THE CIRCLES COMPLETELY. THANKS