

NAME _____ DOB _____ DATE _____

DO YOU HAVE ANY OF THE FOLLOWING CURRENTLY?	CHECK IF YES	DO YOU HAVE ANY OF THE FOLLOWING CURRENTLY?	CHECK IF YES
GENERAL		ENDROCRINE	
FEVER OR CHILLS		FATIGUE	
APPETITE CHANGE		SENSITIVITY TO HEAT	
WEIGHT GAIN		SENSITIVITY TO COLD	
NIGHT SWEATS		THYROID GOITER OR SWELLING	
WEIGHT LOSS		CHANGE IN THIRST	
EYES		HOT FLASHES	
BLURRED VISION		DECREASED SEXUAL INTEREST	
DOUBLE VISION		GENITOURINARY	
CATARACTS		PAINFUL URINATION	
GLAUCOMA		FREQUENT URINATION	
EYE PAIN		SLOW STREAM	
DRY EYES		URINATION AT NIGHT	
WATERY EYES		BLADDER CONTROL PROBLEM	
ITCHY EYES		BLOOD IN URINE	
ENT		URINARY INFECTION	
HEARING LOSS		KIDNEY STONES	
FREQUENT EAR PAIN		VENEREAL DISEASE	
RINGING IN EARS		IRREGULAR VAGINAL BLEEDING	
ALLERGIES OR HAYFEVER			
SINUS TROUBLE		MUSCULOSKELETAL	
NOSE BLEEDS		JOINT PAIN	
HOARSENESS		BACK OR NECK PAIN	
FREQUENT SORE THROAT		ARM OR LEG PAIN	
MOUTH ULCERS		MUSCLE PAIN OR CRAMPS	
DIZZINESS		SKIN	
NASAL CONGESTION		DRY SKIN	
NASAL DRAINAGE		RASHES	
SPINNING		CHANGE IN MOLES/GROWTHS	
OFF BALANCE		PERSISTENT ITCHING	
NECK PAIN		SORE THAT DOES NOT HEAL	
NECK MASS		HAIR LOSS	
FACIAL PAIN		NEUROLOGICAL	
EAR PRESSURE		FREQUENT HEADACHES	
EAR DRAINAGE		MIGRAINE HEADACHES	
CARDIOVASCULAR		NUMBNESS OR ARMS OR LEGS	
HIGH BLOOD PRESSURE		MUSCLE WEAKNESS	
CHEST PAIN OR TIGHTNESS		POOR COORDINATION	
IRREGULAR HEARTBEAT		FALLS	
FAINTING OR DIZZINESS		TREMOR OR SHAKING	
LEG CRAMPS WALKING		TROUBLE SLEEPING	
SWOLLEN ANKLES/ FEET			

DO YOU HAVE ANY OF THE FOLLOWING CURRENTLY?	CHECK IF YES	DO YOU HAVE ANY OF THE FOLLOWING CURRENTLY?	CHECK IF YES
RESPIRATORY		SUBSTANCE ABUSE	
BRONCHITIS OR COUGH		ALCOHOL	
COUGHED BLOOD		DRUG	
WHEEZING		PSYCHIATRIC	
SHORTNESS OF BREATH		DEPRESSION	
GASTROINTESTINAL		ANXIETY	
DIFFICULTY SWALLOWING		MEMORY CHANGE	
HEARTBURN OR INDIGESTION		COUNSELING OR TREATMENT	
ABDOMINAL PAIN		HEMATOLOGIC/LYMPHATIC	
NAUSEA OR VOMITING		SWOLLEN GLANDS	
CONSTIPATION		EASY BRUISING OR BLEEDING	
DIARRHEA		SICKLE CELL DISEASE	
RECTAL BLEEDING		SICKLE CELL TRAIT	
CHANGE IN BOWEL MOVEMENT		ALLERGIC/IMMUNOLOGIC	
BLACK STOOLS		RASHES	
VOMITED BLOOD		DRUG REACTIONS	
YELLOW JAUNDICE		REACTION TO ANESTHESIA	