Patient Name: _____ Date: _____

DO YOU HAVE NOW OR WITH ANY REGULARITY: **(PLEASE CIRCLE)**

CONSTITUTIONAL/ENDOCRINE: **Date of last Flu Shot?** _____

Fever Sweats Chills Headaches Dizziness Weight Gain or Loss Fatigue Skin Rash
Lymph Node Swelling Other: _____ or **NONE OF THE ABOVE**

HEAD/EYES/EARS/NOSE/THROAT:

Sore Throat Visual Disorder Hearing Loss Runny Nose Hoarseness Change in Voice **NONE OF THE ABOVE**

HEART/LUNGS/VASCULAR:

Coughing/Wheezing Irregular Heartbeat Chest tightness/pain Leg Swelling Coughing up blood
Leg Ulcers Shortness of Breath Last Chest X-ray: _____
Last EKG: _____ Other: _____ or **NONE OF THE ABOVE**

GASTRO INTESTINAL:

Changes in appetite Constipation Diarrhea Nausea Vomiting Indigestion/Heartburn
Hemorrhoids Bloody/Black Stools Yellow color to skin/eyes Abdominal bloating/swelling

Bulges visible on abdominal wall? Y or N Last Rectal Exam: _____
Stomach pain that occurs after eating? Y or N If yes, what food? _____
Have you ever had a lower bowel exam with a scope? Y or N If yes, when? _____
Have you ever had an exam with a scope looking at the stomach? Y or N If yes, when? _____
Have you ever been to see a GI Specialist? Y or N If yes, who? _____
or **NONE OF THE ABOVE**

KIDNEY/URINATION:

Frequent urination Urination at night Pain with urination Blood in urine Hard to start/stop flow
Enlarge prostate Impotence Prostate cancer – what type of treatment: _____
Other: _____ or **NONE OF THE ABOVE**

BREAST/GYN: **Date of last Mammo/Breast US?** _____

How many pregnancies? _____ How many children? _____
Are you pregnant Y or N? _____ Date of last menstrual period? _____
Vaginal discharge? _____ Are you on any hormones/birth control medication? _____
Nipple discharge? _____ Breast masses? _____
NONE OF THE ABOVE

NEUROLOGICAL/PSYCHIATRIC:

Depression Anxiety Difficulty sleeping Under Psychiatric care Mood swings
Numbness Tingling Loss of Consciousness Other: _____
or **NONE OF THE ABOVE**

MUSCULOSKELETAL:

Joint swelling Joint pain Muscle weakness Bone pain **NONE OF THE ABOVE**

SKIN:

Rashes Itching Hair Loss **NONE OF THE ABOVE**