NAME______________________________ DOB ______________

Do you CURRENTLY have? (IF YES, CHECK APPROPRIATE BOXES)

GENERAL
- ☐ Fatigue
- ☐ Fever
- ☐ Weight Gain
- ☐ Weight Loss

SKIN
- ☐ Nail Changes
- ☐ New Lesions
- ☐ Rash
- ☐ Skin Color Changes

HEENT
- ☐ Double Vision
- ☐ Eye Pain
- ☐ Eye Redness
- ☐ Decreased Hearing
- ☐ Earache
- ☐ Ear Ringing
- ☐ Nose Bleeds
- ☐ Dry Mouth
- ☐ Hoarseness
- ☐ Oral Ulcers
- ☐ Sore Throat

NECK
- ☐ Neck Pain
- ☐ Swollen Glands

RESPIRATORY
- ☐ Chronic Cough
- ☐ Decreased Exercise Tolerance
- ☐ Difficulty Breathing
- ☐ Coughing Up Blood
- ☐ Sputum Production
- ☐ Wheezing

BREAST
- ☐ Breast Mass
- ☐ Breast Pain
- ☐ Nipple Discharge
- ☐ Skin Changes

CARDIOVASCULAR
- ☐ Chest Pain
- ☐ Leg Pains with walking
- ☐ Leg Swelling
- ☐ Night Awakening due to trouble Breathing
- ☐ Palpitations
- ☐ Shortness of Breath

GASTROINTESTINAL
- ☐ Abdominal Pain
- ☐ Change in Bowel Habits
- ☐ Constipation
- ☐ Diarrhea
- ☐ Nausea
- ☐ Vomiting
- ☐ Rectal Bleeding
- ☐ Trouble Swallowing

GENITOURINARY
- ☐ Difficulty Starting/Stopping urinary Stream
- ☐ Painful Urination
- ☐ Change in Urinary Stream
- ☐ Increased Frequency
- ☐ Blood in Urine
- ☐ Loss of Bladder Control
- ☐ Nighttime Urination
- ☐ Urinary Retention

MEN
- ☐ Urethral Discharge
- ☐ Impotence
- ☐ Penile Lesions
- ☐ Testicular Mass
- ☐ Testicular Pain

WOMEN
- ☐ Vaginal Discharge

MUSCULOSKELETAL
- ☐ Decreased Range of Motion
- ☐ Joint Pain
- ☐ Joint Redness
- ☐ Joint Swelling
- ☐ Joint Stiffness
- ☐ Muscle Wasting
- ☐ Muscle Weakness
- ☐ Muscle Aches/Pains

NEUROLOGICAL
- ☐ Loss of Bowel Control
- ☐ Dizziness/Vertigo
- ☐ Headaches
- ☐ Numbness/Tingling
- ☐ Passing Out
- ☐ Seizures
- ☐ Tremor

PSYCHIATRIC
- ☐ Anxiety
- ☐ Change in Sleep Pattern
- ☐ Depression
- ☐ Hallucinations
- ☐ Suicidal Thoughts

ENDOCRINE
- ☐ Appetite Changes
- ☐ Cold Intolerance
- ☐ Increased Thirst
- ☐ Increased Urination
- ☐ Hair Changes
- ☐ Sexual Dysfunction

HEMATOLOGY
- ☐ Easy Bruising
- ☐ Enlarged Lymph Nodes
- ☐ Prolonged Bleeding

GYNECOLOGICAL/ OBSTETRICAL HISTORY (for women only):

Name of OB-GYN ______________________________

Age you Started Menstruating ________

Menstrual Cycles Regular / Irregular (Please Circle)

Pain with Periods? Yes/No

First day of Last Menstrual Period ________

Age at Menopause ______

Date of Last PAP ________

History of abnormal Paps? Yes / No

Number of Pregnancies______

Number of Births ______

Method of Contraception ________

Date of last bone density test ________

Date of Last Mammogram________

History of Abnormal Mammograms Yes /No

Patient Signature______________________________ Date:__________

Physician Signature______________________________ Date:__________