Name: _____DOB: _____Date: _____

PCP: _____ Referring Provider: _____

General

Fevers	Yes
Chills	Yes
Sweats	Yes
Loss of Appetite	Yes
Fatigue	Yes
Weight Gain or Loss	Yes
Insomnia	Yes
Are you a safe driver?	Yes
Auto accidents in the past year?	Yes

Cardiovascular

Chest pain	Yes
Fainting spells	Yes
Ankle swelling	Yes
Palpitations	Yes
Shortness of breath	Yes

Skin

Unexplained rashes	Yes
Alopecia	Yes
Suspicious lesions	Yes
Unexplained itching	Yes
Visited Dermatologist in past year	Yes

Musculoskeletal

Joint pain	Yes
Muscle cramps	Yes
Muscle weakness	Yes
Joint swelling	Yes
Joint stiffness	Yes
Back pain	Yes
Arthritis	Yes

Endocrine

Cold intolerance	Yes
Increased thirst	Yes
Large quantity of urine	Yes
Heat intolerance	Yes
Increased appetite	Yes

OFFICIAL USE ONLY
Height: _____ Weight: _____
B/P: _____ /_____ Pulse: _____
Handedness: R / L

Ear, Nose and Throat

Ear aches	Yes
Loss of Hearing	Yes
Difficulty swallowing	Yes
Ringing in your ears	Yes
Decreased hearing	Yes
Nasal congestion	Yes

Respiratory

Coughing	Yes
Wheezing	Yes
Night sweats	Yes
Coughing up blood	Yes
Nausea/vomiting more than 7 days	Yes
Unplanned weight loss	Yes
Difficulty chewing/swallowing	Yes
Change in walking ability	Yes

Gastrointestinal

Nausea	Yes
Constipation	Yes
Blood or black stools	Yes
Vomiting	Yes
Changes in bowel habits	Yes
Diarrhea	Yes
Abdominal pain	Yes

Neurologic

Transient limb paralysis	Yes
Tingling sensation	Yes
Headache	Yes
Weakness	Yes
Seizure	Yes
Unsteadiness	Yes
Tremor	Yes
Speech difficulties	Yes
Numbness	

Heme/Lymphatic

Abnormal bruising	Yes
Abnormal bleeding	Yes
Enlarged lymph nodes	Yes

Eyes

Blurred vision	Yes
Double vision	Yes
Loss of partial visual field	Yes
Vision Loss	Yes
Eye pain	Yes
Light sensitivity	Yes
Wear eye glasses	Yes
Eye infections	Yes
Eye injuries	Yes
Glaucoma	Yes
Loss of Side vision	Yes
Vision worse in bright light	Yes
Droopy eyelids	Yes
Flashes of light	Yes
Burning in eyes	Yes
Lazy eye	Yes
Visual hallucinations	Yes
Visual blurring or loss at near	Yes
Visual blurring or loss at distance	Yes

Genitourinary

Pain upon urination	Yes
Blood in urine	Yes
Frequent urination	Yes
Frequent urination at night	Yes
Difficulty starting to urinate	Yes
Loss of bladder control	Yes
Loss of pregnancy/miscarriage	Yes

Psychiatric

Depression	Yes
Hallucination	Yes
Irritability	Yes
Anxiety	Yes
Paranoia	Yes
Panic attacks	Yes
Memory loss	Yes

Allergy/Immunology

Persistent infections	Yes
HIV exposure	Yes