

Do you have, or have you had, any of the following?

General

- Fevero Yes o No
- Weight loss/changeso Yes o No
- Chillso Yes o No
- Fatigueo Yes o No

ENT

- Hearing losso Yes o No
- Mouth soreso Yes o No
- Swallowing difficultieso Yes o No

Cardiac

- Chest paino Yes o No
- High blood pressureo Yes o No
- Palpitationso Yes o No
- Swelling of arms or legso Yes o No

Respiratory

- Chronic cougho Yes o No
- Shortness of breatho Yes o No
- Coughing up bloodo Yes o No
- Varicose veinso Yes o No

Vascular

- Pain in feet at resto Yes o No
- Pain in legs with walkingo Yes o No
- Vascular testingo Yes o No

Gastrointestinal

- Abdominal paino Yes o No
- Nausea/vomitingo Yes o No
- Constipation/diarrheao Yes o No
- Appetite changeso Yes o No

Endocrine

- Heat or cold intoleranceo Yes o No
- Excessive thirsto Yes o No
- Tired/sluggisho Yes o No

Genitourinary

- Blood in urineo Yes o No
- Frequent/painful urinationo Yes o No
- Erectile dysfunctiono Yes o No
- Number of pregnancieso Yes o No

Musculoskeletal

- Joint paino Yes o No
- Back paino Yes o No
- Muscle cramps/paino Yes o No
- Past injurieso Yes o No

Skin/Integumentary

- Rasho Yes o No
- Soreso Yes o No
- Discolorationo Yes o No
- Healing problemso Yes o No

Neurological

- Headacheso Yes o No
- Loss of visiono Yes o No
- Clumsinesso Yes o No
- Arm/leg weaknesso Yes o No
- Seizureso Yes o No
- Burning of toes, feet, handso Yes o No
- Numbness/tinglingo Yes o No
- Difficulty speakingo Yes o No

Psychiatric

- Depressiono Yes o No
- Nervousnesso Yes o No
- Insomniao Yes o No

Hematological/Lymphatic

- Swollen glandso Yes o No
- Phlebitiso Yes o No
- Blood clotting problemso Yes o No

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Date form reviewed _____
 Initials of reviewer _____

Patient Signature _____ Date _____
 Print Name _____