

Name: _____ Age: _____ Date: _____

Please indicate any symptoms you **currently have**:

General

- ___ Weight loss
- ___ Weight gain
- ___ Fever
- ___ Night sweats

Head-ears-nose-throat

- ___ Tooth or gum disease
- ___ Hearing or ear problems
- ___ Sinus problems

Cardio-pulmonary

- ___ Chest pain
- ___ Shortness of breath
- ___ Swelling in the feet
- ___ Chronic cough

Gastrointestinal

- ___ Stomach pain
- ___ Nausea or vomiting
- ___ Constipation
- ___ Diarrhea
- ___ Dark, tarry or bloody stools
- ___ Loss of bowel control

Genitourinary

- ___ Wake up at night to urinate
If so, how many times nightly? _____
- ___ Difficulty starting urination
- ___ Difficulty completely emptying bladder
- ___ Loss of bladder control
- ___ Frequent urge to urinate
- ___ Bloody or dark brown urine
- ___ Pain when urinating

MEN

- Are you sexually active? _____
- ___ Difficulty having or maintaining erection
- ___ Known prostate problems

WOMEN

- ___ Age when menstrual periods began
- ___ Are you sexually active? _____
- ___ Number of pregnancies _____
- ___ Number of children _____
- ___ Last Pap smear _____
Result: _____
- ___ Last mammogram _____
Result: _____
- ___ Irregular periods
- ___ Painful cramps with periods
- ___ Pain during intercourse
- ___ Chronic pelvic pain
- ___ Menopause (Age _____)
- ___ Lumps in breasts

Skin and skeletal

- ___ Skin problems
- ___ Growing or changing mole
- ___ Joint pain
- ___ Fluid in joints
- ___ Chronic back pain

Mood

- ___ Problems sleeping
- ___ Wake up early, can't get back to sleep
- ___ Loss of interest in things you like to do
- ___ Loss of enjoyment of life
- ___ Feelings of guilt or hopelessness
- ___ Feeling sad or depressed
- ___ Change in appetite (loss or increase)
- ___ Crying spells
- ___ Irritable, "short fuse"
- ___ Anxiety

Rate your eye or head pain today

No Pain  Un-bearable pain
10

Reviewed by: _____ Date reviewed _____

Name: _____ **Age:** _____ **Date:** _____

Medications:

List all medications you are taking. Include over-the-counter medications, vitamins, and medications taken "as needed".

	<u>Name of medicine</u>	<u>Dose (mg)</u>	<u>Frequency taken</u>	<u>Why are you taking it?</u>
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____
5.	_____	_____	_____	_____
6.	_____	_____	_____	_____
7.	_____	_____	_____	_____
8.	_____	_____	_____	_____
9.	_____	_____	_____	_____
10.	_____	_____	_____	_____

Allergies:

List all medication allergies, and describe your allergic reaction.

List food or environmental allergies: