CONSTITUTIONAL

Good general health lately	NO	YES
Recent weight change	NO	YES
Fever	NO	YES
Fatigue	NO	YES
Headaches	NO	YES

EYES

Eye disease or injury	NO	YES
Wear glasses	NO	YES
Wear contacts	NO	YES
Blurred or Double vision	NO	YES
Glaucoma	NO	YES

EARS/NOSE/THROAT/NECK

Hearing loss or ringing	NO	YES
Earaches	NO	YES
Chronic sinus problem or rhinitis	NO	YES
Nose bleeds	NO	YES
Mouth sores	NO	YES
Bleeding gums	NO	YES
Bad breath or bad taste	NO	YES
Sore throat or voice change	NO	YES
Swollen glands in neck	NO	YES

CADIOVASCULAR

Heart trouble	NO	YES
Chest pain or pressure	NO	YES
Palpitations	NO	YES
Shortness or breath	NO	YES
Swelling of feet, ankles or hands	NO	YES

RESPIRATORY

Chronic or frequent coughs	NO	YES
Spitting up blood	NO	YES
Shortness of breath	NO	YES
Wheezing	NO	YES

GASTROINTESTINAL

Loss of appetite	NO	YES
Change in bowel movements	NO	YES
Nausea	NO	YES
Vomiting	NO	YES
Frequent diarrhea	NO	YES
Painful bowel movements	NO	YES
Rectal bleeding or blood in stool	NO	YES
Abdominal pain	NO	YES
Heartburn	NO	YES
Peptic ulcer (stomach or duodenal)	NO	YES

GENITOURINARY/NEPHROLOGY

Frequent urination	NO	YES
Burnings or painful urination	NO	YES
Blood in urine	NO	YES
Change in force of stream when urinating	NO	YES
Incontinence or dribbling	NO	YES
Kidney stones	NO	YES
Sexual difficulty	NO	YES
MALE - Testicular pain	NO	YES
FEMALE – Menstrual pain	NO	YES
FEMALE – Menstrual irregularity	NO	YES

GENITOURINARY/NEPHROLOGY (cont.)

FEMALE – Vaginal discharge	NO	YES

FEMALE – No. of pregnancies _____

FEMALE – No. of miscarriages _____

FEMALE – Date of last pap smear _____

MUSKOSKELETAL

Joint pain	NO	YES
Joint stiffness	NO	YES
Joint swelling	NO	YES
Muscle weakness	NO	YES
Muscle pain or cramps	NO	YES
Back pain	NO	YES
Difficulty in walking	NO	YES

DERMATOLOGIC

Rash	NO	YES
Itching	NO	YES
Change in skin color	NO	YES
Change in hair or nails	NO	YES
Varicose veins	NO	YES

NEUROLOGIC

Frequent or recurring headaches	NO	YES
Lightheaded or dizzy	NO	YES
Convulsions or seizures	NO	YES
Numbness or tingling sensations	NO	YES
Tremors	NO	YES
Paralysis	NO	YES
Stroke	NO	YES
Head injury	NO	YES

PHYCHIATRIC

Memory loss of confusion	NO	YES
Nervousness	NO	YES
Depression	NO	YES
Insomnia	NO	YES

ENDOCRINE

Glandular or hormone problem	NO	YES
Thyroid disease	NO	YES
Diabetes	NO	YES
Excessive thirst or urination	NO	YES
Heat or cold intolerance	NO	YES

HEMATOLOGIC / LYMPHATIC

Slow to heal after cuts	NO	YES
Bleeding or bruising tendency	NO	YES
Anemia	NO	YES
Phlebitis (leg vein clot)	NO	YES
Pat transfusion	NO	YES

ALLERGIC/IMMUNOLOGIC

Penicillin or other antibiotics	NO	YES
Morphine, demerol, other narcotics	NO	YES
Novocaine or other anesthetics	NO	YES
Aspirin or other pain remedies	NO	YES
Tetanus antitoxin or other serums	NO	YES
Iodine, methiolate, other antiseptics	NO	YES

Other drugs / medications _____

Known food allergies_____