



PATIENT NAME _____

DATE _____

LIST ANY SURGERIES THAT YOU HAVE HAD IN THE LAST FIVE YEARS:	
<input type="checkbox"/> Uterus	<input type="checkbox"/> Tubes Tied
<input type="checkbox"/> Appendix	<input type="checkbox"/> Hernia
<input type="checkbox"/> Tonsils	<input type="checkbox"/> Gallbladder
<input type="checkbox"/> Heart	OTHER _____

Check any of the following that you have had **RECENTLY**:

- | | | |
|---|---|---|
| <input type="checkbox"/> Fever/chills | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Weight Loss | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Numbness |
| <input type="checkbox"/> Eye pain | <input type="checkbox"/> Pain when Urinating | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Drainage from eyes | <input type="checkbox"/> Frequency of urination | <input type="checkbox"/> Hallucinations |
| <input type="checkbox"/> Ear pain | <input type="checkbox"/> Phlegm | <input type="checkbox"/> Excessive thirst |
| <input type="checkbox"/> Very tired | <input type="checkbox"/> Difficulty breathing | <input type="checkbox"/> Heat or cold intolerance |
| <input type="checkbox"/> Weakness | <input type="checkbox"/> Constipation | <input type="checkbox"/> Excessive thirst |
| <input type="checkbox"/> Recent vision changes | <input type="checkbox"/> Abdominal pain | <input type="checkbox"/> Bleed excessively |
| <input type="checkbox"/> Nasal congestion or bleeding | <input type="checkbox"/> Blood from bowels | <input type="checkbox"/> Joint pain or swelling |
| <input type="checkbox"/> Sore throat | <input type="checkbox"/> Blood in urine | <input type="checkbox"/> Bruise easily |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Flank pain | <input type="checkbox"/> Passing out |
| <input type="checkbox"/> Heart palpitations | <input type="checkbox"/> Neck pain | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Back pain | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Ankle swelling | <input type="checkbox"/> Rash | <input type="checkbox"/> Suicidal thoughts |
| <input type="checkbox"/> Cough | <input type="checkbox"/> Itching | <input type="checkbox"/> Excessive urination |
| <input type="checkbox"/> Wheezes | <input type="checkbox"/> Arm pain | <input type="checkbox"/> Swollen glands |
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Leg pain | <input type="checkbox"/> Change in skin color |
| | <input type="checkbox"/> Headache | |

Do **YOU** have any of the following conditions?

- Diabetes Arthritis AIDS
- Asthma or Lung High Blood Pressure
- Heart Cancer Stroke
- Other: _____

Do you smoke? Yes No

Of packs per day _____ for # of years _____

Do you drink alcohol Yes No

If yes, how many drinks per week? _____

Do you take drugs **NOT** prescribed by a doctor?

- Yes No

Male:

- Testicle pain Discharge from penis

Female:

- Last menstrual period _____ Vaginal discharge
- # of pregnancies _____ Miscarriages
- # of live childbirths _____ Discharge from breast
- Breast pain Other: _____