



- ❖ Please give detail description of the reason you are here to see us: _____

- ❖ When did your symptoms start? _____
- ❖ Your symptoms came on suddenly or gradually? _____
- ❖ Your symptoms have gotten worse / stayed the same / gotten better? _____
- ❖ What makes your symptoms better? _____

- ❖ What makes your symptoms worse? _____

- ❖ What laboratory work up has been done for your condition? _____

- ❖ What radiology work up (e.g. CT scan, MRI, etc.) has been done for your condition? _____

- ❖ What medications have been tried for your condition? _____

- ❖ What doctors have you seen for your condition? _____

- ❖ Do you have family history of similar problems? (circle): Yes / No, If yes, in whom: _____

- ❖ Have you ever had this symptom before? (circle): Yes / No, If yes, when: _____

- ❖ Are you taking any new medications? (circle): Yes / No, If yes, which: _____

- ❖ Are you going through any major life event / stressful situation? (circle): Yes / No, If yes, describe: _____

- ❖ What is worrying you the most about your condition? _____

