MEDICAL HISTORY

Please provide the most accurate and complete informaiton possible:

Current Medications:

Please list any medications you're currently taking (both over the counter, and prescribed)

Medication Name	Dosage	Time Taken

Allergies

Please provide a list of any and all allergies (medication, food, etc.)

Past Surgical History

Please provide a list of any and all past surgical procedures

Procedure	Surgeon	When? (mm/yyyy)

MEDICAL HISTORY

Please indicate any symptoms that are NEW to you:

GENERAL

Chills or Fever	**YES**	**NO**
Night Sweats	**YES**	**NO**
Poor Appetite	**YES**	**NO**
Weight Loss/Weight Gain	**YES**	**NO**
Loss of Energy	**YES**	**NO**

EYES

Sudden Changes in Vision	**YES**	**NO**
Double Vision	**YES**	**NO**
Tearing or Redness	**YES**	**NO**

EARS

Sudden Loss of Hearing	**YES**	**NO**
Ringing in Ears	**YES**	**NO**
Earache	**YES**	**NO**
Frequent Ear Inections	**YES**	**NO**

NOSE

Nasal Congestion	**YES**	**NO**
Frequent Sinus Infections	**YES**	**NO**
Frequent Nose Bleeds	**YES**	**NO**

MOUTH/THROAT

Frequent Throat Infections	**YES**	**NO**
Bleeding Gums	**YES**	**NO**
Change in Voice/Hoarseness	**YES**	**NO**

LUNGS

Chronic Cough	**YES**	**NO**
Coughing Up Blood	**YES**	**NO**
Shortness of Breath	**YES**	**NO**
Wheezing	**YES**	**NO**
Shortness of Breath with Activity	**YES**	**NO**

HEART

Chest Pain / Pressure	**YES**	**NO**
Heart Palpitations	**YES**	**NO**
Irregular Heart Beat	**YES**	**NO**
Using Several Pillows at Night	**YES**	**NO**
Pain in Calves with Walking	**YES**	**NO**
Swelling of Lower Limbs (Legs, Ankles or Feet)	**YES**	**NO**
Waking Up Experiencing Shortness of Breath	**YES**	**NO**

STOMACH / INTESTINES

Difficulty/Painful Swallowing	**YES**	**NO**
Heartburn/Indigestion	**YES**	**NO**
Stomach Pain/Discomfort	**YES**	**NO**
Nausea or Vomiting	**YES**	**NO**
Vomiting Blood	**YES**	**NO**
Blood in Stools	**YES**	**NO**
Constipation	**YES**	**NO**
Chronic Diarrhea	**YES**	**NO**
Use of Laxatives	**YES**	**NO**
Black/Tarry Stools	**YES**	**NO**
History of Jaundice	**YES**	**NO**

ENDOCRINE

Excessive Thirst	**YES**	**NO**
Cold / Heat Intolerance	**YES**	**NO**
Hot Flashes	**YES**	**NO**

NERVOUS SYSTEM

Severe Headaches	**YES**	**NO**
Hand Tremors	**YES**	**NO**
Dizziness / Lightheadedness	**YES**	**NO**
Loss of Balance	**YES**	**NO**
Fainting/Passing out	**YES**	**NO**
Numbness or Tingling	**YES**	**NO**
Paralyzed Arms/Legs	**YES**	**NO**
Slurred Speech	**YES**	**NO**

MUSCULOSKELETAL

Back Pain	**YES**	**NO**
Painful Joints	**YES**	**NO**
Swelling of the Joints	**YES**	**NO**
Stiff Joints	**YES**	**NO**
Muscle Aches	**YES**	**NO**
Muscle Weakness	**YES**	**NO**

SKIN

Skin Rashes	**YES**	**NO**
Skin Discoloration	**YES**	**NO**
Easy Bruising	**YES**	**NO**
Excessive Itching	**YES**	**NO**
Hair Loss	**YES**	**NO**
Finger/Toe Nail Changes	**YES**	**NO**

BLOOD

Anemia	**YES**	**NO**
Blood Loss	**YES**	**NO**
History of Blood Transfusion	**YES**	**NO**

PSYCHIATRIC

Mood Swings	**YES**	**NO**
Depression	**YES**	**NO**
Anxiety	**YES**	**NO**
Problems Sleeping	**YES**	**NO**
Hallucinations	**YES**	**NO**
Memory Loss	**YES**	**NO**

WOMEN ONLY

Menopause	**YES**	**NO**
Irregular Periods	**YES**	**NO**
Abnormal Vaginal Bleeding	**YES**	**NO**
Complicated Pregnancies	**YES**	**NO**
Miscarriages	**YES**	**NO**

MEN ONLY

Impotence	**YES**	**NO**
Prostate Issues	**YES**	**NO**
Weak or Slow Urinary Stream	**YES**	**NO**