250 Chateau Dr SW, Suite 115

Huntsville, AL 35803

Premier Wound Care & ID Specialist

PH: 256.533.4645

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Name_____DOB_____Date_____

Please indicate if you have been diagnosed with, or experienced any of the following conditions <u>within the past two weeks</u>.

REVIEW OF SYSTEMS	YES	NO	REVIEW OF SYSTEMS	YES	NO
CONSTITUTIONAL			**INFECTIOUS DISEASE**		
Chills			Gonorrhea		
Fatigue			Hepatitis		
Fever			HIV/AIDS		
Weight Loss			Syphilis		
EYES			Tuberculosis		
Eye Pain			**GASTROINTESTINAL**		
Visual Changes			Heartburn/Reflux		
Cataracts			Nausea/Vomiting		
Glaucoma			Abdominal Pain		
EAR/NOSE/THROAT			Constipation		
Difficulty Hearing			Diarrhea		
Ringing in ears			Black or Bloody stool		
Vertigo			**RESPIRATORY**		
Sinusitis			Cough		
CARDIOVASCULAR			Wheezing		
Palpitations			**PSYCHIATRIC**		
Chest Pain			Anxiety/Depression		
Dizziness/Fainting spells			Mood Swings		
Shortness of Breath			Difficulty Sleeping		
Leg/Ankle Swelling			**MUSCULOSKELETAL**		
HEMATOLOGICAL			Back Pain		
Blood Transfusion			Joint Pain/Swelling		
Blood Clot/DVT			Stiffness		
CANCER			Muscle Pain		
What kind?			**NEUROLOGICAL**		
INTEGUMENTARY (SKIN)			Headaches		
Lymphedema			Loss of Strength		
Rash			Numbness		
Sores/Lesions			Seizures		
Itching/Burning			**CANCER**		
			What kind?		