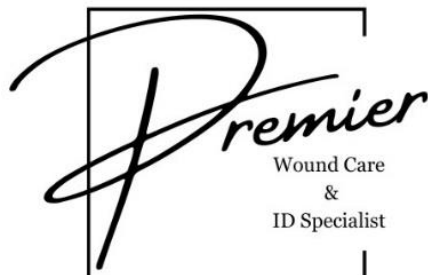


250 Chateau Dr SW, Suite 115  
Huntsville, AL 35803



PH: 256.533.4645  
FAX: 256.808.3178

Name \_\_\_\_\_ DOB \_\_\_\_\_ Date \_\_\_\_\_

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

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