Name:_____

DOB:_____

Medical History:

High blood pressure
High cholesterol
Diabetes
Stroke
Venous Thrombosis (DVT)
Ischemic Vascular Disease (atherosclerosis)
Heart Attack
Coronary Artery Disease
Erectile Dysfunction
Kidney Disease; Type_____
COPD
Cancer; Type_____
Thyroid Disorder; Type_____
Esophageal Reflux
Seizure Disorder
Asthma
Sleep Apnea
Osteoporosis
Blood Disorder; Type_____
Mental Illness
Hepatitis
Other: _____

Do you Currently have any of the following symptoms?

General Symptoms

Significant Weight Loss
- (circle) Gained / Lost #lbs_____

Change in Appetite
Fever
Chills
Tiring Easily/ Weakness

Physician Initials: _____

Endocrine

Heat / Cold Intolerance
Excessive Thirst
Excessive Sweating

Skin

Sores that don't heal
Color changes to hands/ feet
Lesions or rashes
Hair loss; location_____

Ears/ Nose/ Mouth/ Throat/ Neck

Hearing Loss
Nose bleeds
Difficulty Swallowing
Bleeding Gums
Mouth sores
Throat Pain
Hoarseness
Neck Lumps or Goiter
Neck Pain / Stiffness

Eyes

Glasses or Contacts
Loss of Vision
Double or Blurred Vision

Cardiovascular

Chest pain or discomfort
Irregular or Fast Heart Rate
Palpatations
Swollen Legs

Respiratory

Cough
Shortness of Breath
-at Rest or With Exertion
Wheezing

Gastrointestinal

Heart burn or GERD
Ulcer
Nausea
Abdominal Pain
Bowel Changes

Genitourinary

Frequent urination
Painful urination
Blood in Urine
Incontinence

Musculoskelatal

Back Pain
Joint Pain
Joint Stiffness
Muscle Aches

Neurologic

Headaches
Episodes of Difficulty Speaking
Numbness or Tingling
Difficulty moving arms/legs
Dizziness or Vertigo

Hematologic/Lymphatic

Easily Bruise
Bleed a long time
Swollen glands

Psychological

Difficulty with sleep
Anxiety
Depression