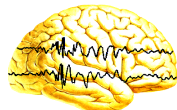


- ❖ Please give a detailed description of the reason you are here to see us: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
- ❖ When did your symptoms start? \_\_\_\_\_
- ❖ Did your symptoms come on suddenly or gradually? \_\_\_\_\_
- ❖ Your symptoms have gotten 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: \_\_\_\_\_



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❖ What is worrying you the most about your condition? \_\_\_\_\_

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