# Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Reason for Visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**General Cardiovascular**

Weight Change O Yes O No Chest Pain O Yes O No

*Circle: Gain or loss* Irregular Heartbeat O Yes O No

Fatigue O Yes O No Swelling of Extremities O Yes O No

Fever O Yes O No Poor Circulation O Yes O No

Night Sweats O Yes O No Previous Heart Attack O Yes O No

**Ophthalmologic Hematology**

Dry eye O Yes O No Blood Clotting Problems O Yes O No

Pain O Yes O No Prolonged Bleeding O Yes O No

Anemia O Yes O No

**ENT Genitourinary**

Hoarseness O Yes O No Blood in Urine O Yes O No

Mouth Sores O Yes O No Painful Urination O Yes O No

Sinus Problems O Yes O No

Sore Throat O Yes O No **Musculoskeletal**

Swollen Glands O Yes O No Back Pain O Yes O No

Muscle aches O Yes O No

Arthritis O Yes O No

**Endocrine Neurologic**

Cold Intolerance O Yes O No Gait Abnormality O Yes O No

Heat Intolerance O Yes O No Tingling/Numbness O Yes O No

**Respiratory Skin**

Cough O Yes O No Itching O Yes O No

Hemoptysis O Yes O No Rash O Yes O No

Shortness of breath O Yes O No Skin Lesion(s) O Yes O No

Wheezing O Yes O No

**Breast (female) Psychiatric**

Breast Lump O Yes O No Anxiety O Yes O No

Breast Pain O Yes O No Depressed Mood O Yes O No

Nipple Discharge O Yes O No Substance Abuse O Yes O No

**Gastrointestina**l

Nausea O Yes O No

Vomiting O Yes O No

Abdominal Pain O Yes O No

Change in bowl habits O Yes O No

Hemorrhoids O Yes O No