CONSTITUTIONAL SYMPTOMS

GOOD GENERAL HEALTH..... NO YES
RECENT WEIGHT CHANGE..... NO YES
FEVER..... NO YES
FATIGUE..... NO YES

EYES

EYE DISEASE OR INJURY..... NO YES
WEAR GLASSES/CONTACTS..... NO YES
BLURRED OR DOUBLE VISION..... NO YES
GLAUCOMA..... NO YES

EARS/NOSE/MOUTH/THROAT

HEARING LOSS OR RINGING..... NO YES
EARACHES OR DRAINAGE..... NO YES
CHRONIC SINUS PROBLEM..... NO YES
NOSE BLEEDS..... NO YES
MOUTH SORES..... NO YES
BLEEDING GUMS..... NO YES
BAD BREATH OR BAD TASTE..... NO YES
SORE THROAT OR VOICE CHANGE.... NO YES
SWOLLEN GLANDS IN NECK..... NO YES

CARDIOVASCULAR

HEART TROUBLE..... NO YES
CHEST PAIN OR ANGINA PECTORIS... NO YES
PALPITATION..... NO YES
SHORTNESS OF BREATH W/WALKING NO YES
SHORTNESS OF BREATH W/LYING NO YES
SWELLING OF FEET, ANKLES, HANDS NO YES

RESPIRATORY

SHORTNESS OF BREATH..... NO YES
ASTHMA OR WHEEZING..... NO YES

GASTROINTESTINAL

LOSS OF APPETITE ..... NO YES
CHANGE IN BOWEL MOVEMENTS.... NO YES
NAUSEA OR VOMITING..... NO YES
FREQUENT DIARRHEA ..... NO YES
CONSTIPATION ..... NO YES
RECTAL BLEEDING/BLOOD IN STOOL NO YES
HEARTBURN..... NO YES
PEPTIC ULCER ..... NO YES

GENITOURINARY

FREQUENT URINATION..... NO YES
BURNING/PAINFUL URINATION..... NO YES
BLOOD IN URINE..... NO YES
CHANGE IN FORCE OF STRAIN..... NO YES
INCONTINENCE OR DRIBBLING..... NO YES
KIDNEY STONES..... NO YES
SEXUAL DIFFICULTY..... NO YES
MALE – TESTICLE PAIN..... NO YES
FEMALE – PAIN W/PERIODS..... NO YES
FEMALE – IRREGULAR PERIODS .... NO YES
FEMALE – VAGINAL DISCHARGE..... NO YES
FEMALE - #PREGNANCIES _____
FEMALE - # MISCARRIAGES _____
FEMALE – DATE LAST PAP SMEAR _____

MUSCULOSKELETAL

JOINT PAIN ..... NO YES
JOINT STIFFNESS OR SWELLING..... NO YES
WEAKNESS OF MUSCLES/JOINTS..... NO YES
MUSCLE PAIN OR CRAMPS..... NO YES
BACK PAIN..... NO YES
COLD EXTREMITIES..... NO YES
DIFFICULTY IN WALKING..... NO YES

INTEGUMENTARY (SKIN, BREAST)

RASH OR ITCHING..... NO YES
CHANGE IN SKIN COLOR..... NO YES
CHANGE IN HAIR OR NAILS..... NO YES
VARICOSE VEINS..... NO YES
BREAST PAIN..... NO YES
BREAST LUMP..... NO YES
BREAST DISCHARGE..... NO YES

NEUROLOGICAL

FREQUENT / RECURRING HEADACHES NO YES
HOW OFTEN _____
LIGHT HEADED OR DIZZY..... NO YES
CONVULSIONS OR SEIZURES..... NO YES
NUMBNESS OR TINGLING..... NO YES
TREMORS..... NO YES
PARALYSIS..... NO YES
STROKE ..... NO YES
HEAD INJURY..... NO YES
MOTION SICKNESS..... NO YES
FAMILY HISTORY OF HEADACHES... NO YES

PSYCHIATRIC

MEMORY LOSS OR CONFUSION..... NO YES
NERVOUSNESS ..... NO YES
DEPRESSION..... NO YES
INSOMNIA..... NO YES

ENDOCRINE

THYROID DISEASE ..... NO YES
DIABETES ..... NO YES
EXCESSIVE THIRST OR URINATION.. NO YES
HEAT OR COLD INTOLERANCE..... NO YES

HEMATOLOGIC/LYMPHATIC

SLOW TO HEAL AFTER CUTS..... NO YES
BLEEDING OR BRUISING TENDANCY.. NO YES
ANEMIA..... NO YES
PAST TRANSFUSION..... NO YES

ALLERGIC/IMMUNOLOGIC

HISTORY OF SKIN REACTION OR OTHER ADVERSE REACTION TO:

PENICILLIN OR ANTIBIOTICS NO YES
MORPHINE,DEMEROL OR NARCOTICS NO YES
NOVOCAINE OR ANESTHETICS NO YES
ASPIRIN OR PAIN REMEDIES NO YES
TETANUS ANTITOXIN OR SERUMS NO YES
IODINE, METHIOLATE OR ANTISEPTIC NO YES
OTHER DRUGS/MEDICATIONS _____

KNOWN FOOD ALLERGIES _____

NAME: _____ **DATE:** _____