



Do you currently have any problems in the following areas? If YES – please provide additional information

YES NO Details

<b>EYES</b> (poor vision, eye pain, tearing, redness, etc)			
<b>GENERAL / CONSTITUTIONAL</b> (fever, heat stroke weight loss, weight gain, unusually tired)			
<b>EARS / NOSE / THROAT</b> (hard of hearing, stuffy nose, earache, cough, dry mouth, etc)			
<b>CARDIVASCULAR</b> (high blood pressure, racing pulse, etc.)			
<b>RESPIRATORY</b> (congestion, wheezing, short of breath, etc)			
<b>GASTROINTESTINAL</b> (stomach upset, diarrhea, constipation, hernia, ulcers, etc.)			
<b>GENITAL , KIDNEY, BLADDER</b> (painful urination, frequent urination, impotence, yellow jaundice, etc.			
<b>FEMALES</b> Are you pregnant? Nursing?			
<b>MUSCLES, BONES, JOINTS</b> (joint pain, stiffness, swelling, cramps, arthritis, etc.)			
<b>SKIN</b> (pimples, warts, growths, rash, etc.)			
<b>NEUROLOGICAL</b> (numbness, headache, seizures, paralysis, etc.)			
<b>PSYCHIATRIC</b> (anxiety, depression, insomnia, etc.)			
<b>ENDOCRINE</b> (diabetes, thyroid, etc.)			
<b>BLOOD / LYMPH</b> (bleeding, choleserolemia, anemia, problems related to blood transfusions, etc.)			
<b>ALLERGIC / IMMUNOLOGIC</b> (sneezing, swelling, redness, itching, hives, lupus, MS, etc.)			

History reviewed (date)	No Changes noted by patient	Changes Listed here:	Reviewed by : (tech/dr)

Doctor

Date

Patient

Date