

Patient Name _____

Date of Birth _____ / _____ / _____

Respiratory:

- | | No | Yes |
|---------------------------------|-----------------------|-----------------------|
| URI(cold) now | <input type="radio"/> | <input type="radio"/> |
| Spitting up blood | <input type="radio"/> | <input type="radio"/> |
| Chronic or frequent cough | <input type="radio"/> | <input type="radio"/> |
| Asthma or wheezing | <input type="radio"/> | <input type="radio"/> |
| Difficulty breathing | <input type="radio"/> | <input type="radio"/> |
| Any trouble with lungs | <input type="radio"/> | <input type="radio"/> |
| Pleurisy or Pneumonia | <input type="radio"/> | <input type="radio"/> |

Cardiovascular:

- | | | |
|--|-----------------------|-----------------------|
| Chest pain or angina pectoris | <input type="radio"/> | <input type="radio"/> |
| Shortness of breath with walking or lying down | <input type="radio"/> | <input type="radio"/> |
| Difficulty walking two blocks | <input type="radio"/> | <input type="radio"/> |
| Heart trouble or heart attacks | <input type="radio"/> | <input type="radio"/> |
| High blood pressure | <input type="radio"/> | <input type="radio"/> |
| Swelling of hands, feet or ankles | <input type="radio"/> | <input type="radio"/> |
| Awakening in the night smothering | <input type="radio"/> | <input type="radio"/> |
| Heart murmur | <input type="radio"/> | <input type="radio"/> |

Gastrointestinal:

- | | | |
|--|-----------------------|-----------------------|
| Peptic ulcer (stomach or duodenal) | <input type="radio"/> | <input type="radio"/> |
| Vomiting blood or food | <input type="radio"/> | <input type="radio"/> |
| Gallbladder disease | <input type="radio"/> | <input type="radio"/> |
| Liver trouble | <input type="radio"/> | <input type="radio"/> |
| Hepatitis | <input type="radio"/> | <input type="radio"/> |
| Painful bowel movements | <input type="radio"/> | <input type="radio"/> |
| Bleeding with bowel movements | <input type="radio"/> | <input type="radio"/> |
| Black stools | <input type="radio"/> | <input type="radio"/> |
| Hemorrhoids or piles | <input type="radio"/> | <input type="radio"/> |
| Recent change in bowel habits | <input type="radio"/> | <input type="radio"/> |
| Frequent diarrhea | <input type="radio"/> | <input type="radio"/> |
| Heartburn or indigestion | <input type="radio"/> | <input type="radio"/> |
| Cramping or pain in the abdomen | <input type="radio"/> | <input type="radio"/> |
| Does food stick in throat | <input type="radio"/> | <input type="radio"/> |

Genitourinary:

- | | | |
|------------------------------------|-----------------------|-----------------------|
| Loss of urine | <input type="radio"/> | <input type="radio"/> |
| Frequent urination | <input type="radio"/> | <input type="radio"/> |
| Night time urinating | <input type="radio"/> | <input type="radio"/> |
| Burning or painful urination | <input type="radio"/> | <input type="radio"/> |
| Blood in urine | <input type="radio"/> | <input type="radio"/> |
| Kidney trouble | <input type="radio"/> | <input type="radio"/> |
| Kidney stones | <input type="radio"/> | <input type="radio"/> |
| Bright's disease | <input type="radio"/> | <input type="radio"/> |

Gynecological:

- Age periods started _____
How long do periods last? _____

Gynecological (con't):

- Number of pregnancies _____
Number miscarriages _____
Date of last cancer smear
and results _____
Frequency of periods, every _____ days
Any pain with periods _____ No Yes
Number of children _____ Ages _____
Date of first day of last period _____ / _____ / _____

Loco-Musculoskeletal:

- | | No | Yes |
|---|-----------------------|-----------------------|
| Varicose veins | <input type="radio"/> | <input type="radio"/> |
| Weakness of muscles or joints | <input type="radio"/> | <input type="radio"/> |
| Any difficulty in walking | <input type="radio"/> | <input type="radio"/> |
| Any pain in calves or buttocks on walking
relieved by rest | <input type="radio"/> | <input type="radio"/> |

Neuro-Psychiatric:

- Have you ever had psychiatric care?
- | | | |
|---|-----------------------|-----------------------|
| <input type="radio"/> | <input type="radio"/> | |
| Have you been advised to see a
psychiatrist? | <input type="radio"/> | <input type="radio"/> |
| <input type="radio"/> | <input type="radio"/> | |
| Do you have, or ever had, fainting spells? | <input type="radio"/> | <input type="radio"/> |
| <input type="radio"/> | <input type="radio"/> | |
| Convulsions | <input type="radio"/> | <input type="radio"/> |
| <input type="radio"/> | <input type="radio"/> | |
| Paralysis | <input type="radio"/> | <input type="radio"/> |
| <input type="radio"/> | <input type="radio"/> | |

Hematologic:

- | | | |
|---|-----------------------|-----------------------|
| Are you slow to heal after cuts | <input type="radio"/> | <input type="radio"/> |
| Blood disease | <input type="radio"/> | <input type="radio"/> |
| Anemia | <input type="radio"/> | <input type="radio"/> |
| Phlebitis | <input type="radio"/> | <input type="radio"/> |
| Have you had difficulty with bleeding ex-
cessively after tooth extraction or surgery? | <input type="radio"/> | <input type="radio"/> |
| Have you had abnormal bruising or bleeding? | <input type="radio"/> | <input type="radio"/> |

Allergic:

- Any allergies, including medications
- | | |
|-----------------------|-----------------------|
| <input type="radio"/> | <input type="radio"/> |
|-----------------------|-----------------------|

Endocrine:

- | | | |
|--|-----------------------|-----------------------|
| Thyroid Disease | <input type="radio"/> | <input type="radio"/> |
| Hormone therapy | <input type="radio"/> | <input type="radio"/> |
| Any change in hat or glove size | <input type="radio"/> | <input type="radio"/> |
| Any change in hair growth | <input type="radio"/> | <input type="radio"/> |
| Have you become colder than before
or skin become dryer | <input type="radio"/> | <input type="radio"/> |

Height: _____ foot _____ inches

Weight: _____ lbs.