Print Name: **BirthDate:**

DIRECTIONS: Please answer each question by circling the number, example: (3) for yes and filling in the blank.
Put a check by any numbers you wish to discuss w/ Doctor or medical assistant.

GENERAL

1 Have you gained more than 10 pounds in the last 6 months?
2 Have you lost more than 10 pounds in the last 6 months?
3 Have you recently lost your interest in eating?
4 Are you more thirsty than usual lately?
5 Are there any swellings in your armpits or groin area?
6 Do you have fever or chills?
7 Do you feel exhausted or fatigued most of the time?
8 Do you feel that you eat a healthy diet?
9 Do you get aerobic exercise? How often? _____
10 Do you have difficulty with sleep?
11 Do you have any excessive bleeding or bruising?
12 Do you take or have you used any illegal drugs?

CARDIOVASCULAR

1 Are you bothered by a pounding, racing or skipping heartbeat?
2 Do you get pains or tightness in your chest?
3 Do you have trouble with feeling lightheaded or passing out?
4 Do you get severely short of breath with exhertion or exercise?
5 Do you wake up at night short of breath?
6 Do you have trouble with swollen ankles or feet?
7 Do you get cramps in your legs while walking?
8 Have you ever been told you have a heart murmur?
9 How many pillows do you sleep on? _____ list #

URINARY

1 Do you leak urine?
2 Do you have pain or burning when you urinate?
3 Is your urine bloody or black?
4 Do you have a constant feeling that you need to urinate?
5 How many times do you have to get up at night to urinate?
_____ times per night

MUSCULOSKELETAL & SKIN (where?)

1 Are you troubled with painful or stiff joints?_____
2 Do you have any skin problems? _____

FOR MEN ONLY

1 Have you ever had any burning or discharge from your penis?
2 Are there any swelling or lumps on your testicles?
3 Have you had difficulties getting or keeping an erection?

NEUROLOGICAL / PSYCHOLOGICAL

1 Do you usually feel sad or lonely?
2 Do you have time-periods of feeling super-energized, needing little sleep & making poor choices?
3 Have you ever been emotionally or physically abused? Was it by someone important to you?
4 Is any part of your body always numb?
5 Have you ever had any seizures or convulsions?
6 Have you ever had a stroke or severe head injury?
7 Do you frequently feel anxious or stressed?
8 Have you ever attempted suicide?
9 Has anyone in your family died by suicide?

DIGESTIVE

1 Are you ever troubled by heartburn or indigestion?
2 Is it difficult or painful for you to swallow?
3 Are your bowel movements bloody or black?
4 Have you had any bleeding from your rectum?
5 Are you having diarrhea or constipation?

HEENT

1 Do you have frequent headaches?
2 Do you have poor vision?
3 Do you have poor hearing?
4 Do you have poor sense of smell?
5 Do you have problems with your mouth or teeth?

RESPIRATORY

1 Do you have wheezing, cough or shortness of breath?
2 Are you bothered by hay fever?
3 Do you snore or do others say that you snore?

FOR WOMEN ONLY

1 What is the first day of your last menstrual period? _____ (date)
2 Are your periods regular?
3 Have you had any recent vaginal discharge or itching?
4 Have you noticed any lumps or swelling in your breasts?
5 How many times have you been pregnant? _____
6 Have you had any miscarriages? How many? _____
7 Have you had any abortions? #_____ at ages? _____
8 How many living children do you have? _____

Patient's Signature: **Date**