HEALTH SURVEY- please check all that currently apply.

CONSTITUTIONAL SYMPTOMS:
____Good general health lately
____Recent weight change
____Fever
____Fatigue

EARS/NOSE/MOUTH/THROAT:
____Hearing loss or ringing
____Earaches or drainage
____Chronic sinus problem or rhinitis
____Mouth sores
____Sore throat
____Swollen glands in neck

CARDIOVASCULAR:
____Heart trouble
____Chest pain or angina pectoris
____Palpitation
____Swelling of feet, ankles
____High blood pressure
____High Cholesterol

RESPIRATORY:
____Chronic coughs
____Spitting up blood
____Shortness of breath
____Asthma or wheezing
____COPD/ Emphysema
____Sleep apnea

GASTROINTESTINAL:
____Loss of appetite
____Nausea or vomiting
____Frequent diarrhea
____Constipation
____Rectal bleeding or blood in stool
____Abdominal pain
____Heartburn
____Peptic ulcer (stomach or duodenal)
____Irritable bowel syndrome
____History of diverticulitis

GENITOURINARY
____Frequent urination
____Burning or painful urination
____Blood in urine
____Kidney stones
____Male: Testicle pain
____Female: Menstruation problems

MUSCULOSKELETAL:
____Arthritis
____Back pain
____Cold extremities
____Difficulty in walking
____Other musculoskeletal symptoms

INTEGUMENTARY (skin, breast):
____Skin changes
____Varicose veins
____Breast pain
____Breast Lump
____Breast Discharge

NEUROLOGICAL:
____Frequent headaches
____Light headed or dizzy
____Seizures
____Numbness or tingling sensations
____Tremors
____Paralysis
____History of Stroke
____Head injury

PSYCHIATRIC:
____Memory loss or confusion
____Anxiety
____Depression
____Insomnia

ENDOCRINE:
____Diabetes
____Enlarged glands
____Hormonal problems
____Thyroid disease
____Thyroid problems
____Excessive thirst or urination

HEMATOLOGIC/ LYMPHATIC
____Anemia
____Bleeding or bruising tendency
____Blood transfusion
____Enlarged lymph nodes
____Phlebitis
____Slow to heal after cuts
____History of chemotherapy
____History of radiation

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his staff responsible for any errors or omissions that I may have made in completion of this form.

_____ _____
Patient Signature Date

_____ _____
Reviewed By Date