

Previous Surgery None

Dates

1. _____

2. _____

3. _____

4. _____

RECENT DIAGNOSTIC TESTS (Please check all that apply within the past 3-6 months)

___ Chest Xray

___ Stress Test

___ Blood Work

___ EKG

REVIEW OF SYMPTOMS (Please check all that apply within last 3-6 months)

GENERAL

- ___ None
- ___ Fever
- ___ Chills
- ___ Night Sweats
- ___ Weight Change

CHEST

- ___ None
- ___ Cough
- ___ Cold
- ___ Sputum
- ___ Coughing up blood
- ___ Wheezing
- ___ Shortness of breath
- ___ Chest pain
- ___ Palpitations
- ___ Heart murmur
- ___ Swelling of feet
- ___ Rheumatic fever

URINARY

- ___ None
- ___ Blood in urine
- ___ Burning with urination
- ___ Bladder or kidney infections
- ___ Frequency and/or difficulty starting urination
- ___ Sense of full bladder
- ___ Difficulty with leaking urine
- ___ Getting up at night to urinate

SKIN

- ___ None
- ___ Rash
- ___ Itching
- ___ Psoriasis
- ___ Change in color or bleeding of mole

HEAD

- ___ None
- ___ Headaches
- ___ Blackouts
- ___ Seizures
- ___ Dizziness
- ___ Hearing Loss
- ___ Double and/or blurred vision
- ___ Ringing in ears
- ___ Sinusitis
- ___ Post nasal drip
- ___ Sore throat
- ___ Hoarseness
- ___ Cold

ABDOMEN

- ___ None
- ___ Nausea
- ___ Vomiting
- ___ Pain and/or difficulty swallowing
- ___ Gas
- ___ Indigestion
- ___ Abdominal pain
- ___ Bloating
- ___ Constipation
- ___ Diarrhea
- ___ Hemorrhoids
- ___ Bloody stools

MUSCULOSKELATAL

- ___ None
- ___ Fracture
- ___ Sprains
- ___ Strains
- ___ Dislocations

NEUROMUSCULAR

- ___ None
- ___ Joint stiffness
- ___ Joint pain
- ___ Swelling
- ___ Back pain
- ___ Varicose veins
- ___ Night cramps
- ___ Bursitis
- ___ Tendonitis
- ___ Raynaud's

FEMALE PATIENTS

Do you take Birth Control Pills? ___ YES ___ NO

If YES, what type? _____

Do you take Premarin, Estrogen or other hormone replacements? ___ YES ___ NO

If YES, what type? _____

Is there any possibility that you are pregnant? ___ YES ___ NO