

GENERAL SYMPTOMS Check symptoms you currently have or have had in the past year.

<u>GENERAL</u>	<u>EYE, EAR, NOSE, THROAT</u>	<u>GASTRO-INTESTINAL</u>	<u>SKIN</u>
<input type="checkbox"/> AIDS/HIV	<input type="checkbox"/> Blurred Vision	<input type="checkbox"/> Poor Appetite	<input type="checkbox"/> Changes in moles
<input type="checkbox"/> Anemia	<input type="checkbox"/> Double Vision	<input type="checkbox"/> Bloating/Gas	<input type="checkbox"/> Skin Cancer
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Blindness	<input type="checkbox"/> Indigestion	<input type="checkbox"/> Eczema/Psoriasis
<input type="checkbox"/> Bleeding Disorders	<input type="checkbox"/> Floaters or Haloes	<input type="checkbox"/> Nausea	<input type="checkbox"/> Hives/Rash
<input type="checkbox"/> Cancer/Tumors	<input type="checkbox"/> Cataracts	<input type="checkbox"/> Reflux	<input type="checkbox"/> Sores not healing
<input type="checkbox"/> Chemical Dependency	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Bowel Changes	WOMEN ONLY
<input type="checkbox"/> Depression	<input type="checkbox"/> Vertigo (dizziness)	<input type="checkbox"/> Constipation	<input type="checkbox"/> Abnormal Periods
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Ringing in ears	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Hot Flashes
<input type="checkbox"/> Difficulty Sleeping	<input type="checkbox"/> Hearing Loss	<input type="checkbox"/> Loss of bowel control	<input type="checkbox"/> Extreme Cramps
<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Earache	<input type="checkbox"/> Rectal Bleeding	<input type="checkbox"/> Spotting
<input type="checkbox"/> Fainting or Seizures	<input type="checkbox"/> Nasal Drip	<input type="checkbox"/> Colitis/IBS	<input type="checkbox"/> Discharge
<input type="checkbox"/> Forgetfulness	<input type="checkbox"/> Nosebleeds	<input type="checkbox"/> Black/Bloody Stool	<input type="checkbox"/> Dysmenorrhea
<input type="checkbox"/> Night Sweats	<input type="checkbox"/> Throat Hoarseness	<input type="checkbox"/> Excessive Hunger	<input type="checkbox"/> Cysts/Tumors
<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Chronic Cough	<input type="checkbox"/> Excessive Thirst	<input type="checkbox"/> Endometriosis
<input type="checkbox"/> Paralysis	<input type="checkbox"/> Allergies/Hayfever	<input type="checkbox"/> Hernia	<input type="checkbox"/> Breast Lumps/Pain
<input type="checkbox"/> Stroke	<input type="checkbox"/> Bleeding Gums	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Miscarriage
<input type="checkbox"/> Tiredness	<input type="checkbox"/> Difficulty Swallowing	<input type="checkbox"/> Weight Trouble	Date of last menstrual period _____
<input type="checkbox"/> Weight Change (dramatic)	<input type="checkbox"/> Slurred Speech	<input type="checkbox"/> High Cholesterol	Are you pregnant? _____
CARDIOVASCULAR	RESPIRATORY	GENITO-URINARY	If so, how far along are you? _____
<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Asthma	<input type="checkbox"/> Milky/Bloody Urine	Number of children? _____
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Painful Urination	MEN ONLY
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Difficulty starting flow	<input type="checkbox"/> Lump in testicles
<input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> Mono	<input type="checkbox"/> Difficulty stopping flow	<input type="checkbox"/> Erection Difficulties
<input type="checkbox"/> Irregular heart beat	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Bladder Trouble	<input type="checkbox"/> Discharge
<input type="checkbox"/> Pacemaker	<input type="checkbox"/> COPD	<input type="checkbox"/> Frequent Urination	<input type="checkbox"/> Prostate Problems
<input type="checkbox"/> Varicose Veins	<input type="checkbox"/> Bloody Mucus	<input type="checkbox"/> Incontinence	
<input type="checkbox"/> Poor Circulation	<input type="checkbox"/> Shortness of Breath		

HEAD, NECK, BACK, EXTREMITIES Check symptoms you currently have or have had in the past year.

<u>HEAD</u>	<u>MIDBACK</u>	<u>HIPS, LEGS & FEET</u>	Left	Right
<input type="checkbox"/> Headaches	<input type="checkbox"/> Midback pain	<input type="checkbox"/> Pain in buttocks	<input type="checkbox"/> L	<input type="checkbox"/> R
<input type="checkbox"/> Migraines	<input type="checkbox"/> Midback stiffness	<input type="checkbox"/> Pain in hip joint	<input type="checkbox"/> L	<input type="checkbox"/> R
<input type="checkbox"/> Face pain	<input type="checkbox"/> Pain between shoulder blades	<input type="checkbox"/> Pain down leg	<input type="checkbox"/> L	<input type="checkbox"/> R
<input type="checkbox"/> Jaw pain	<input type="checkbox"/> Muscle spasms in midback	<input type="checkbox"/> Pain in knee	<input type="checkbox"/> L	<input type="checkbox"/> R
NECK	<input type="checkbox"/> Midback feels out of place	<input type="checkbox"/> Pain in ankle	<input type="checkbox"/> L	<input type="checkbox"/> R
<input type="checkbox"/> Pain in neck	LOWER BACK	<input type="checkbox"/> Pain in foot	<input type="checkbox"/> L	<input type="checkbox"/> R
<input type="checkbox"/> Neck stiffness	<input type="checkbox"/> Pain in lower back	<input type="checkbox"/> Pain in toes	<input type="checkbox"/> L	<input type="checkbox"/> R
<input type="checkbox"/> Neck weakness	<input type="checkbox"/> Lower back stiffness	<input type="checkbox"/> Pins/needles in leg	<input type="checkbox"/> L	<input type="checkbox"/> R
<input type="checkbox"/> Grinding sounds in neck	<input type="checkbox"/> Muscle spasms in lower back	<input type="checkbox"/> Pins/needles in toes	<input type="checkbox"/> L	<input type="checkbox"/> R
<input type="checkbox"/> Tingling in neck	<input type="checkbox"/> Lower back feels out of place	<input type="checkbox"/> Numbness in leg	<input type="checkbox"/> L	<input type="checkbox"/> R
<input type="checkbox"/> Neck feels out of place	ARMS & HANDS	<input type="checkbox"/> Numbness in foot/toes	<input type="checkbox"/> L	<input type="checkbox"/> R
SHOULDERS	<input type="checkbox"/> Pain in upper arm	<input type="checkbox"/> Weakness of leg	<input type="checkbox"/> L	<input type="checkbox"/> R
<input type="checkbox"/> Pain in shoulder joint	<input type="checkbox"/> Pain in elbow	<input type="checkbox"/> Weakness of knee	<input type="checkbox"/> L	<input type="checkbox"/> R
<input type="checkbox"/> Pain across tops of shoulders	<input type="checkbox"/> Pain in forearm	<input type="checkbox"/> Leg cramps	<input type="checkbox"/> L	<input type="checkbox"/> R
<input type="checkbox"/> Can't raise arm	<input type="checkbox"/> Pain in hand/fingers	<input type="checkbox"/> Cold feet	<input type="checkbox"/> L	<input type="checkbox"/> R
<input type="checkbox"/> Above shoulder level	<input type="checkbox"/> Pins/needles feeling in arm	OTHER SYMPTOMS		
<input type="checkbox"/> Overhead	<input type="checkbox"/> Pins/needles feeling in finger	_____		
<input type="checkbox"/> Tingling in shoulder	<input type="checkbox"/> Numbness in arm	_____		
<input type="checkbox"/> Tension in shoulder	<input type="checkbox"/> Numbness in hand/fingers	_____		
<input type="checkbox"/> Numbness in shoulder	<input type="checkbox"/> Weak arm/hand	_____		

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

Signature _____

Date _____