

Name _____

Date _____

Do you currently have any of these complaints?

Constitutional

- Fever
- Fatigue
- Night Sweats
- Sleep Disorder
- Other _____

Respiratory

- Wheezing
- Cough
- Coughing up Blood
- Shortness of Breath
- Other _____

Genitourinary

- Frequent Urination
- Painful Urination
- Blood in Urine
- Passing Urine at Night
- Incontinence
- Other _____

Endocrine

- High Blood Sugar
- Low Blood Sugar
- Heat/Cold Intolerance
- Other _____

Eyes

- Blindness
- Glaucoma
- Retinal Problems
- Other _____

Cardiovascular

- Irregular Heart Beats
- Fast Heart Rate
- Fainting
- Chest Pain
- Shortness of Breath
- Ankle Swelling
- Leg Pain with Walking
- Other _____

Gynecological

- Vaginal Discharge
- Pelvic Pain
- Abnormal Pap Smear
- Abnormal Vaginal Bleeding
- Irregular Cycles
- Last Gyne Exam _____
- Are you/could you be pregnant?
- Other _____

**Hematologic/
Lymphatic**

- Easy Bruising
- Clotting Disorder
- Enlarged Lymph Node
- Other _____

**Ears, Nose, Mouth
& Throat**

- Earaches
- Ringing in the Ears
- Dizziness
- Nose Bleed
- Sinus Problems
- Dental Problems
- Bleeding Gums
- Sore Throat
- Change in Voice
- Painful Swallowing
- Difficulty Swallowing
- Other _____

Gastrointestinal

- Weight Loss
- Weight Gain
- Decreased Appetite
- Nausea/Vomiting
- Vomiting Blood
- Black Stools
- Bloody Stools
- Jaundice
- Bloating
- Constipation
- Diarrhea
- Abdominal Pain
- Other _____

**Allergy/Immune
System**

- Immune Deficiency
- AIDS/HIV
- Plant Allergy
- Animal Allergy
- Chemical Allergy
- Other _____

Neurologic

- Headaches
- Seizures
- Paralysis
- Weakness on One Side
- Slurred Speech
- Other _____

Psychiatric

- Mental Illness
- Depression
- Drug/Alcohol Abuse
- Other _____

Skin

- Rash
- Skin Cancer
- Itching
- Other _____

Patient Signature

Date

Physician Signature

Patient Signature

Date

Physician Signature

Patient Signature

Date

Physician Signature