

Today's Date _____

Chart # _____

Name: _____ MRN # _____

INDICATE WHICH APPLY TO YOU

GENERAL

- | | | |
|--|--------------------------|--------------------------|
| | Yes | No |
| 1. Frequent infections | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Weight change | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Appetite/thirst change | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Excessive fatigue/nervousness | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Difficulty sleeping | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Enlarged/tender lymph nodes or glands | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Other _____ | | |

EYES

- | | | |
|---------------------------------|--------------------------|--------------------------|
| | Yes | No |
| 1. Do you wear glasses/contacts | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Vision changes | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Red/itchy, watery eyes | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Eye pain | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Glaucoma | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Dry eyes | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Other _____ | | |

EARS

- | | | |
|----------------------|--------------------------|--------------------------|
| | Yes | No |
| 1. Infections | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Hearing loss | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Earaches | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Ear drainage | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Buzzing/ringing | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Feel "stopped up" | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Other _____ | | |

NOSE AND THROAT

- | | | |
|--|--------------------------|--------------------------|
| | Yes | No |
| 1. Nasal stuffiness/drainage | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Frequent nosebleeds | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Sore throat | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Mouth sores/ulcers | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Hoarseness | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Changes in taste | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Teeth/gum problems | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Snoring | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Sleep apnea (stop breathing while sleeping) | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Other _____ | | |

PULMONARY

- | | | |
|---|--------------------------|--------------------------|
| | Yes | No |
| 1. Shortness of breath/difficulty breathing | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Cough-dry/productive | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Asthma/wheezing | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Night sweats | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Fever/chills | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Other _____ | | |

CARDIOVASCULAR

- | | | |
|--------------------------------|--------------------------|--------------------------|
| | Yes | No |
| 1. Heart attack/failure/angina | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Chest pain/tightness | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Irregular heartbeat | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. High blood pressure | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Swelling of feet/ankles | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Leg cramps with walking | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Mitral Valve/Murmur | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Other _____ | | |

GASTROINTESTINAL

- | | | |
|---------------------------------------|--------------------------|--------------------------|
| | Yes | No |
| 1. Heartburn /indigestion | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Difficulty swallowing | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Stomach pains/ulcers | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Nausea/vomiting | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Vomiting blood | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Loose stools/diarrhea | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Constipation | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Hemorrhoids | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Rectal bleeding | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Black/bloody stools | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Changes in bowel habits | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Frequent laxatives | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Liver problems/jaundice/hepatitis | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Gallstones | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Other _____ | | |

BREAST

- | | | |
|----------------|--------------------------|--------------------------|
| | Yes | No |
| 1. Lumps | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Pain | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Discharge | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Other _____ | | |

MALES ONLY

- | | | |
|---|--------------------------|--------------------------|
| | Yes | No |
| 1. Prostate problems | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Sexual difficulties | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Testicle pain/lumps/swelling | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Impotent | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Discharge | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Do you do regular testicle exams | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Date of last prostate exam / PSA _____ | | |
| 8. Venereal disease | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Genital concerns | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Other _____ | | |

FEMALES ONLY

- | | | |
|---|--------------------------|--------------------------|
| | Yes | No |
| 1. Excessive menstrual flow | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Excessive menstrual pain | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Vaginal discharge/odor | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Vaginal dryness | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. PMS symptoms | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Menopause/symptoms | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Trouble conceiving | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Problems with pregnancies | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Sexual difficulties | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Venereal disease | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Genital concerns | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Self breast exams per year _____ | | |
| 13. Do you use birth control Type _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Date of last pap _____ | | |
| 15. History of Abnormal Pap Treatment _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Date of last mammogram _____ | | |
| 17. Age at onset of periods _____ | | |
| 18. Frequency of periods _____ | | |

FEMALES ONLY (continued)

- | | | |
|----------------------------------|--|--|
| 19. Last menstrual period _____ | | |
| 20. Pregnancies _____ | | |
| 21. Live births _____ | | |
| 22. Miscarriages/abortions _____ | | |
| 23. Other _____ | | |

MUSCULOSKELETAL

- | | | |
|--------------------------|--------------------------|--------------------------|
| | Yes | No |
| 1. Joint pain/tenderness | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Joint swelling/warmth | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Joint stiffness | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Joint deformity | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Muscle pain | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Back/neck pain | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Weakness | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Prone to falls | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Other _____ | | |

SKIN

- | | | |
|------------------------|--------------------------|--------------------------|
| | Yes | No |
| 1. Rashes | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Dry/itchy skin | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Bruising | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Sweats | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Mole/lesion changes | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Skin color changes | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Skin growths | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Hair/nail problems | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Other _____ | | |

NEUROLOGIC

- | | | |
|--------------------------|--------------------------|--------------------------|
| | Yes | No |
| 1. Headaches/migraines | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Dizziness/nausea | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Fainting/blackouts | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Numbness/tingling | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Paralysis | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Seizures/convulsions | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Coordination problems | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Memory loss | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Other _____ | | |

PSYCHIATRIC

- | | | |
|---------------------------------|--------------------------|--------------------------|
| | Yes | No |
| 1. Mental illness | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Anxiety | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Depression | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Suicidal thoughts | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Overly emotional/mood swings | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Hallucinations | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Phobias | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Other _____ | | |

URINARY

- | | | |
|------------------------------|--------------------------|--------------------------|
| | Yes | No |
| 1. Pain/burning on urination | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Urinary frequency | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Difficulty starting urine | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Incontinence (wetting) | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Bloody urine | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Other _____ | | |

Provider Review: _____ Date: _____

Provider Review: _____ Date: _____

Provider Review: _____ Date: _____

