Name: _____ Age:_____: Date: _____

If there has been any change in your address, phone, or Insurance, please indicate the correct information below:

_____

_____

YES NO

☐☐ 1. Has there been anything hurting you or bothering you lately? If YES, please specify below:

_____

_____

_____

☐☐ 2. Have your changed your medication since your last visit? If Yes, Please specify below:

_____

_____

_____

☐☐ 3. Has there been any change in you employment, martial status, or lifestyle since your last visit? If YES, please specify?

_____

_____

☐☐ 4. Do you have frequent or severe headaches?

☐☐ 5.Have you had any change in your vision?

☐☐ 6.Do you have any problems with your hearing or balance?

☐☐ 7.Do you have any sinus problems?

☐☐ 8.Do you have any difficulty swallowing?

☐☐ 9.Do you have a cough or problems breathing?

☐☐ 10.Do you have chest pain or pressure?

☐☐ 11.Have you experienced any irregular heart beat?

☐☐ 12.Have you had any abdominal pain?

☐☐ 13.Have you noticed any black stools or red blood in your stools?

☐☐ 14.Have you noticed any change in your bowel habits?

YES NO

☐ ☐ 15. Have you had any serious infections to your knowledge? If YES, describe:

_____

_____

☐ ☐ 16. Have you had any difficulty with your urination?

☐ ☐ 17. Do you have any significant aches, pains, or swelling in any of your joints?

☐ ☐ 18. Have you had any weakness, numbness, or tingling in your arms or legs?

☐ ☐ 19. Are you currently smoking cigarettes or using tobacco in any form?

☐ ☐ 20. Are you sexually active?

☐ ☐ 21. Do you exercise on a regular basis? If YES, please describe:

Type of exercise: Duration: Frequency:

_____

_____

☐ ☐ 22. Is your appetite normal for you?

☐ ☐ 23. Is your energy level normal for you? If NOT, describe activities you formerly could do but no longer do because of lack of energy.

A. _____

B. _____

C. _____

D. _____

☐ ☐ 24. Have you recently had fever or excess sweating?

☐ ☐ 25. In an average week how many drinks of alcohol (beer, whine, or hard liqour) will you consume? _____ average drinks per week.

☐ ☐ 26. Since your last visit, have you experienced any symptoms not described above? If YES, describe:

_____

_____

☐ ☐ 27. Since your last visit, have you had medical care rendered by another health care professional or institution? If YES, please describe:

Name of Physician or Facility: _____

_____

Date you were seen: _____