PATIENT HISTORY QUESTIONNAIRE

REVIEW OF SYSTEMS: (PLEASE CIRCLE YES OR NO)

CONSTITUTIONAL

Good General Health	YES	NO
Recent Weight Change	YES	NO
Night Sweats/Fevers	YES	NO
Fatigue	YES	NO

CARDIOVASCULAR

Chest Pain	YES	NO
Palpitations	YES	NO
Heart Trouble	YES	NO
Swelling Hands/Feet	YES	NO

MUSCULOSKELETAL

Muscle Pain/Cramps	YES	NO
Stiffness/Swelling Joints	YES	NO
Joint Pain	YES	NO
Trouble Walking	YES	NO

ENDOCRINE

Excessive Thirst/Urination	YES	NO
Thyroid Disease	YES	NO
Hormone Problems	YES	NO

GENITO-URINARY

Blood In Urine	YES	NO
Kidney Stones	YES	NO
Difficulty Urinating	YES	NO
Incontinence Problems	YES	NO

GASTRO-INTESTINAL

Nausea/Vomiting	YES	NO
Abdominal Pain	YES	NO
Rectal Bleeding	YES	NO
Bowel Problems	YES	NO

ALLERGIES

Food Allergies	YES	NO
Drug Allergies	YES	NO

Please List: _____

_____

EARS/NOSE/THROAT/MOUTH

Hearing Loss/Ringing	YES	NO
Sinus Problems	YES	NO
Nose Bleeds	YES	NO
Sore Throat/Voice Change	YES	NO

RESPIRATORY

Shortness Of Breath	YES	NO
Cough	YES	NO
Wheezing/Asthma	YES	NO
Coughing Up Blood		

NEUROLOGICAL

Frequent Headaches	YES	NO
Paralysis or Tremors	YES	NO
Convulsions/Tremors	YES	NO
Numbness/Tingling	YES	NO

HEMATOLOGIC/LYMPHATIC

Bruise Easily	YES	NO
Slow To Heal	YES	NO
Enlarged Glands	YES	NO

EYES

Wear Glasses/Contacts	YES	NO
Eye Disease/Injury	YES	NO
Glaucoma	YES	NO

INTEGUMENTARY (SKIN)

Change In Hair Or Nails	YES	NO
Rashes Or Itching	YES	NO

PSYCHIATRIC

Insomnia	YES	NO
Confusion/Memory Loss	YES	NO
Depression	*YES*	*NO*

PATIENT STATEMENT: To The Best Of My Knowledge The Above Information Is Complete And Accurate.

Signed: _____ Date: _____