

SYSTEM REVIEW: CHECK IF YOU HAVE HAD ANY OF THE FOLLOWING SYMPTOMS OR FINDINGS TO AN UNUSUAL OR SIGNIFICANT DEGREE:

HEADACHE..... <input type="checkbox"/>	TROUBLE SWALLOWING <input type="checkbox"/>	HEART TROUBLE..... <input type="checkbox"/>	HYPOGLYCEMIA..... <input type="checkbox"/>
FAINING..... <input type="checkbox"/>	LOSS OF APPETITE..... <input type="checkbox"/>	HEART MURMER..... <input type="checkbox"/>	THYROID TROUBLE..... <input type="checkbox"/>
DIZZINESS..... <input type="checkbox"/>	INDIGESTION..... <input type="checkbox"/>	RHEUMATIC FEVER..... <input type="checkbox"/>	GOITER..... <input type="checkbox"/>
SEIZURE..... <input type="checkbox"/>	HEART BURN..... <input type="checkbox"/>	PALPITATION..... <input type="checkbox"/>	HOT FLASHES..... <input type="checkbox"/>
EAR TROUBLE..... <input type="checkbox"/>	NERVOUS STOMACH..... <input type="checkbox"/>	IRREGULAR HEART BEAT..... <input type="checkbox"/>	FLUID RETENTION..... <input type="checkbox"/>
SINUS TROUBLE..... <input type="checkbox"/>	ULCER..... <input type="checkbox"/>	TIRE EASILY..... <input type="checkbox"/>	WEAKNESS..... <input type="checkbox"/>
STUFFY NOSE..... <input type="checkbox"/>	VOMITING BLOOD..... <input type="checkbox"/>	ANGINA..... <input type="checkbox"/>	NUMBNESS..... <input type="checkbox"/>
NOSE BLEEDS..... <input type="checkbox"/>	PASSING BLOOD..... <input type="checkbox"/>	ENLARGED HEART..... <input type="checkbox"/>	NERVOUS..... <input type="checkbox"/>
ALLERGY..... <input type="checkbox"/>	ABDOMINAL PAIN..... <input type="checkbox"/>	HIGH BLOOD PRESSURE..... <input type="checkbox"/>	IRRITABLE..... <input type="checkbox"/>
HOARSENESS..... <input type="checkbox"/>	COLITIS..... <input type="checkbox"/>	ANKLE SWELLING..... <input type="checkbox"/>	DEPRESSED..... <input type="checkbox"/>
EYE TROUBLE..... <input type="checkbox"/>	DIARRHEA..... <input type="checkbox"/>	ARTHRITIS..... <input type="checkbox"/>	TIRED..... <input type="checkbox"/>
COUGH..... <input type="checkbox"/>	CONSTIPATION..... <input type="checkbox"/>	BACK PAIN..... <input type="checkbox"/>	PARALYSIS..... <input type="checkbox"/>
WHEEZING..... <input type="checkbox"/>	HEMORRHOIDS..... <input type="checkbox"/>	BURSITIS..... <input type="checkbox"/>	SLEEP PROBLEMS..... <input type="checkbox"/>
PLEURISY..... <input type="checkbox"/>	CHANGE IN BOWEL HABITS..... <input type="checkbox"/>	MUSCLE CRAMPS..... <input type="checkbox"/>	KIDNEY PROBLEMS..... <input type="checkbox"/>
PNEUMONIA..... <input type="checkbox"/>	YELLOW JAUNDICE (HEPATITIS)..... <input type="checkbox"/>	URINE INFECTION..... <input type="checkbox"/>	TUBERCULOSIS..... <input type="checkbox"/>
VARICOSE VEINS..... <input type="checkbox"/>	GALLBLADDER TROUBLE..... <input type="checkbox"/>	DIFFICULTY URINATING..... <input type="checkbox"/>	SHORTNESS OF BREATH..... <input type="checkbox"/>
LIVER DISEASE..... <input type="checkbox"/>	PHLEBITIS..... <input type="checkbox"/>	PROSTATE TROUBLE..... <input type="checkbox"/>	NIGHT SWEATS..... <input type="checkbox"/>
ANEMIA..... <input type="checkbox"/>	ABNORMAL ELECTROCARDIOGRAM... <input type="checkbox"/>	SUGAR IN URINE..... <input type="checkbox"/>	FEVER..... <input type="checkbox"/>
BLOOD DISORDER..... <input type="checkbox"/>	BLOOD IN URINE..... <input type="checkbox"/>	CHEST PAIN..... <input type="checkbox"/>	SKIN TROUBLE..... <input type="checkbox"/>
ABNORMAL X-RAY..... <input type="checkbox"/>	INFERTILITY..... <input type="checkbox"/>	COUGHED UP BLOOD..... <input type="checkbox"/>	TUMOR OR SWELLING..... <input type="checkbox"/>
HIGH BLOOD SUGAR... <input type="checkbox"/>	IMPOTENCE..... <input type="checkbox"/>	ASTHMA..... <input type="checkbox"/>	DIABETTES..... <input type="checkbox"/>
LOW BLOOD SUGAR... <input type="checkbox"/>	SEXUAL DISTRESS..... <input type="checkbox"/>	OTHER..... <input type="checkbox"/>	OTHER..... <input type="checkbox"/>

ACTIVITY: (CHECK ALL THAT APPLY):

1. SEDENTARY LIFE WITH LITTLE EXERCISE..... <input type="checkbox"/>	3. OCCASIONAL VIGOROUS ACTIVITY WITH WORK OR RECREATION..... <input type="checkbox"/>
2. MILD EXERCISE WITH JOB, HOUSE OR RECREATION (CLIMB STAIRS, WALK OVER 3 BLOCKS, GOLF, BOWL, and ECT)..... <input type="checkbox"/>	4. REGULAR VIGOROUS EXERCISE PROGRAM OR HARD WORK..... <input type="checkbox"/>

FOR WOMEN ONLY

DATE LAST MENSTRUATED _____	ANY MENSTRUAL PROBLEMS? YES___ NO___
PERIODS EVERY _____ DAYS	HEAVY PERIODS _____
	IRREGULAR PERIODS _____
	INFREQUENT PERIODS _____
	PAINFUL PERIODS _____
	SPOTTING _____
	DISCHARGE _____
	OTHER (EXPLAIN) _____

NUMBER OF PREGNANCIES _____ NUMBER OF MISCARRIAGES _____ BIRTH CONTROL METHOD _____ DATE OF LAST PAP SMEAR _____

CHECK IF YOU HAVE HADE:

D&C..... HYSTERECTOMY..... TOXEMIA..... CESAREAN SECTION.....

DIFFICULTY WITH PREGNANCY _____ WITH LABOR _____ WITH DELIVERY _____

PATIENT SIGNATURE _____ DATE _____