FIRST NAME____________________MIDDLE_____________________LAST_________________________

REVIEW OF SYMPTOMS-CHECK ONLY THE ONES YOU *NOW* HAVE OR HAVE HAD *RECENTLY*

GENERAL
- ☐ Weakness
- ☐ Fatigue
- ☐ Fever
- ☐ Chills
- ☐ Night Sweats
- ☐ Fainting
- ☐ None

SKIN
- ☐ Skin Rashes
- ☐ Itchy Skin
- ☐ Skin Dryness
- ☐ Skin Sores
- ☐ Skin Color Changes
- ☐ Nail Changes
- ☐ Hair Changes
- ☐ Moles
- ☐ Hives
- ☐ Eczema
- ☐ Angioedema
- ☐ None

HEAD
- ☐ Headaches
- ☐ Head Injuries
- ☐ Sinus Congestion/Pressure
- ☐ Pressure around eyes
- ☐ Facial Swelling
- ☐ Blurred Vision
- ☐ Sinus Pain
- ☐ None

EYES
- ☐ Itching
- ☐ Eye Redness
- ☐ Tearing
- ☐ Burning Eyes
- ☐ Eye Swelling
- ☐ Dry Eyes
- ☐ Eye Pain
- ☐ Blurred Vision
- ☐ Watery Eyes
- ☐ None

EARS
- ☐ Itchy Ears
- ☐ Earache/Ear Infection
- ☐ Deafness
- ☐ Ear Discharge
- ☐ Loss of balance
- ☐ Dizziness
- ☐ Room Spins
- ☐ Ringing
- ☐ Hard of Hearing
- ☐ None

NOSE
- ☐ Sneezing
- ☐ Nasal Congestion
- ☐ Runny Nose
- ☐ Yellow/Greenish Drainage
- ☐ Nasal Obstruction
- ☐ Post Nasal Drip
- ☐ Loss of Smell
- ☐ Deviated Septum
- ☐ Nasal Pain
- ☐ Nasal Discharge
- ☐ Nose Bleeds
- ☐ Sinus Infection
- ☐ Itchy Nose
- ☐ Nasal Drainage
- ☐ None

MOUTH
- ☐ Snoring
- ☐ Mouth Breathing
- ☐ Oral Ulcers
- ☐ Dental Problems
- ☐ Oral Blisters
- ☐ Dry Mouth
- ☐ Bad Taste
- ☐ Loss of Taste
- ☐ Bad Breath
- ☐ Dental Problems
- ☐ Bleeding Gums
- ☐ None

THROAT
- ☐ Recurrent Infections
- ☐ Bad Tonsils
- ☐ Sore Throat
- ☐ Hoarseness
- ☐ Throat Drainage
- ☐ Hard to Swallow
- ☐ Oral White Spots
- ☐ None

NECK
- ☐ Neck Enlargement
- ☐ Neck Stiffness
- ☐ Neck Soreness
- ☐ Neck Pain
- ☐ Neck Lumps
- ☐ Neck Masses
- ☐ None

BREASTS
- ☐ Nipple Discharge
- ☐ Breast Lumps/Nodules
- ☐ Pain/Tenderness
- ☐ Nipple Changes
- ☐ Breast Skin Changes
- ☐ Breast Bloatedness
- ☐ Breast Masses
- ☐ Nipple Bleeding
- ☐ None

LUNGS
- ☐ Asthma
- ☐ Pneumonia
- ☐ Shortness of Breath
- ☐ Wheezing
- ☐ Environmental Exposure
- ☐ Chest Congestion
- ☐ Cough
- ☐ Phlegm
- ☐ Coughed Blood
- ☐ Short of Breath w/exertion
- ☐ None

HEART
- ☐ Murmur
- ☐ Palpitations
- ☐ Rapid Heartbeat
- ☐ Swollen Extremities
- ☐ Cold Extremities
- ☐ Chest Tightness/Pressure
- ☐ Chest Pain
- ☐ Varicose Veins
- ☐ Blood Clots
- ☐ Blue Extremities
- ☐ None

BLOOD
- ☐ Anemia
- ☐ Broken Blood Vessels
- ☐ Easy Bruising
- ☐ Prolonged Bleeding
- ☐ Swollen Nodes
- ☐ Painful Nodes
- ☐ Red Dots/Spots
- ☐ None

GASTROINTESTIONAL
- ☐ Food Intolerance
- ☐ Abdominal Pain
- ☐ Nausea
- ☐ Vomiting
- ☐ Abdominal Bloatedness
- ☐ Belching
- ☐ Heartburn
- ☐ Indigestion
- ☐ Irregular Bowels
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive Abdominal Gas
- ☐ Hemorrhoids/Rectal Bleeding
- ☐ Poor Appetite
- ☐ Bloody Stools
- ☐ Excessive Appetite
- ☐ None

MUSCULOSKELETAL
- ☐ Muscular Pain
- ☐ Muscle Weakness
- ☐ Muscular Cramps
- ☐ Muscle Twitching
- ☐ Joint Stiffness
- ☐ Joint Pains
- ☐ Joint Swelling
- ☐ Joint Deformities
- ☐ Injuries
- ☐ Curvature of the Spine
- ☐ Back Pain
- ☐ None

NEUROLOGICAL
- ☐ Seizures
- ☐ Vertigo
- ☐ Tingling/Burning
- ☐ Loss of Memory
- ☐ Hard to Concentrate
- ☐ Disorientation
- ☐ None

PSYCHIATRIC
- ☐ Hyperventilation
- ☐ Depression
- ☐ Insomnia
- ☐ Irritable
- ☐ Anxiousness/Stress
- ☐ Hallucinations
- ☐ Suicidal Thoughts
- ☐ Obsessiveness
- ☐ Sexual Dysfunction
- ☐ Panic Attacks
- ☐ None

ENDOCRINE
- ☐ Weight Loss
- ☐ Weight Gain
- ☐ Loss of Hair
- ☐ Extreme Thirst
- ☐ Voice Changes
- ☐ Excessive Hair Growth
- ☐ Hypoglycemia/Low Blood
- ☐ Diabetes/High Blood
- ☐ None

CURRENT MEDICATIONS-Include dosage and directions for use

ALLERGIES-List any known allergies including food and medication

List ALL Known Allergies	Describe type of allergic reaction

PAST MEDICAL HISTORY-Please provide a complete history

List illnesses, injuries & operations	Date	Physician/Hospital	Treatment	Response

Immunizations/Vaccinations		Last chest x-ray: date:_______☐ normal ☐ abnormal
☐ current for age	☐ is not current for age	Last sinus x-ray: date:_______☐ normal ☐ abnormal

FAMILY HISTORY-List all relatives with current health status-*especially note allergies or asthma history*

Blood Relative	Health Status excellent, good, fair, poor	Age Living At Death	Cause of Death	Illnesses &/Or Allergies / Asthma History
Father				
Mother				
Siblings				
Children				

SOCIAL HISTORY-Please check the appropriate boxes and fill in accurate amounts

PLEASE COMPLETE FOR AGES 12 AND ABOVE ONLY

Mental Work	☐ Omit	☐ Light	☐ Moderate	☐ Heavy
Physical Work	☐ Omit	☐ Light	☐ Moderate	☐ Heavy
Exercise	☐ Omit	☐ Light	☐ Moderate	☐ Heavy
	Hours per week:___	Type of exercise:	1.	2.

Alcohol	☐ Never	Beers ___oz. per wk	Liquor__oz. per wk	Wine___oz. per wk
Tobacco	☐ Never	☐ Current	☐ Cigarettes _______per day	☐ Cigars_________ ________per day
		☐ Marijuana ________per day	☐ Other__________ _________per day	
Caffeine	☐ Never	☐ Coffee/Tea Cups per day______	☐ Soft Drinks/Colas Cups per day______	☐ Other__________ Cups per day______
Aspirin	☐ Never	# per day_________	# of years________	
Nutrition	☐ Normal Diet	☐ Diabetic Diet	☐ Low Fat Diet	☐ Other__________
Miscellaneous Non-Prescription Drugs	☐ Amphetamines ☐ Antacids ☐ ____________	☐ Cocaine ☐ Diet Pills ☐ Eye Drops	☐ Laxatives ☐ Marijuana ☐ Nasal Sprays	☐ Pain Pills ☐ Sleeping Pills ☐ ______________