Please check any item that applies to the patients current health

Any item left unmarked will be assumed negative

General ☐ Weight Loss ☐ Fever ☐ Fatigue	**Eyes** ☐ Glasses ☐ Blurred Vision ☐ Eye Pain/Discomfort	**Skin** ☐ Rashes ☐ Sores ☐ Itching/Burning
Cardiovascular ☐ Irregular Heart Beat ☐ Chest Pain ☐ Fainting Spells ☐ Blood Pressure Problems	**Allergies** ☐ Hives/Eczema ☐ Food Allergies ☐ New Medication Allergies Please Specify:	**Gastrointestinal** ☐ Diarrhea ☐ Heartburn ☐ Blood in Stool ☐ Vomiting
Endocrine ☐ Loss of Hair ☐ Heat/Cold Intolerance ☐ Thyroid Problems	**Respiratory** ☐ Cough ☐ Wheezing ☐ Shortness of Breath	**Genitourinary** ☐ Pain with urination ☐ Blood in urine ☐ Increased urine frequency
Musculoskeletal ☐ Joint Pain/Swelling ☐ Weakness ☐ Muscle Pain	**Neurological** ☐ Headaches ☐ Seizures ☐ Dizziness	**Hematology** ☐ Bleeding Problems ☐ Anemia ☐ Easy Bruising

Circle all that apply below

Social History Changes- No Change Smoking Alcohol Other

Family History Changes- No Change Diabetes Heart Trouble Hypertension Breathing Problems Other

Patient Name _ **Date of Birth _**

Patient Signature _ **Date Confirmed _**