Name:_____ Date:_____ Medical Doctor: _____

Last menstrual period: _____ Medications: _____

Please check any of the following symptoms that apply to you. Thank You.

CONSTITUTIONAL	**YES**	**NO**
Weight loss	___	___
Weight gain	___	___
Change in height	___	___
Fever	___	___
EYES/EARS/NOSE/THROAT		
Vision changes	___	___
Earaches	___	___
Hearing problems	___	___
Sore throat	___	___
Mouth sores	___	___
CARDIOVASCULAR		
Chest pain	___	___
Swelling of legs	___	___
Rapid/irregular heartbeat	___	___
RESPIRATORY		
Coughing up blood	___	___
Shortness of breath	___	___
Chronic cough	___	___
Wheezing	___	___
GASTROINTESTINAL		
Frequent diarrhea	___	___
Bloody stool	___	___
Nausea/vomiting	___	___
Constipation	___	___
Change in bowel habits	___	___
Abdominal bloating	___	___
Frequent indigestion	___	___
Hemorrhoidal pain	___	___
URINARY		
Blood in urine	___	___
Pain with urination	___	___
Strong urgency to urinate	___	___
Frequent urination	___	___
Incomplete emptying	___	___
Involuntary urine loss	___	___
Urine loss w/cough/lift	___	___
GYNECOLOGICAL		
Abnormal bleeding	___	___
Painful periods	___	___
Painful intercourse	___	___
Abnormal vaginal discharge	___	___
Itching	___	___
Possible contact with sexually transmitted disease	___	___
Bleeding with intercourse	___	___

MUSCULOSKELETAL	**YES**	**NO**
Muscle weakness	___	___
Muscle/joint pain	___	___
SKIN		
Bruises	___	___
Rash	___	___
Changes in moles	___	___
BREASTS		
Pain in breasts	___	___
Nipple discharge	___	___
Lumps	___	___
NEUROLOGIC		
Seizures	___	___
Dizziness	___	___
Numbness	___	___
Frequent/severe headaches	___	___
PSYCHIATRIC		
Feeling down/sad	___	___
Feeling anxious	___	___
ENDOCRINE		
Heat/cold intolerance	___	___
Abnormal thirst	___	___
Hot flashes	___	___
Chronic fatigue	___	___
HEMATOLOGIC/LYMPHATIC		
Cuts that do not stop bleeding	___	___
Enlarged lymph nodes/glands	___	___
ALLERGIC/IMMUNOLOGIC		
Medication allergies?	___	___
List:_____		
Other allergies?	___	___
List:_____		
Do you drink alcohol?	___	___
How much?_____		
Do you smoke?	___	___
How much?_____		
Do you exercise?	___	___
Would you like information on domestic violence?	___	___