<INSERT PATIENT LABEL> **Date**

# READ CAREFULLY!

## INDICATE WHAT SYMPTOMS YOU ARE FEELING NOW.

| Lifestyle | | | | |
|---|---|---|---|---|
| | **Yes** | **No** | **Explain (if necessary)** | |
| **Are you generally well?** | | | | |
| **Smoker** | | | _____ packs per day | |
| **Alcohol** | | | _____ glasses per day or week | |
| **Coffee or Tea** | | | _____ cups per day | |
| **Heart Active Exercise** | | | _____ Minutes or hours per week | |
| **General** | | | | |
| | **Good** | **Fair** | **Poor** | **Explain (if necessary)** |
| **Appetite** | | | | |
| **Energy level** | | | | |
| **Sleep** | | | | |
| | **Yes** | **No** | **Explain (if necessary)** | |
| **Unexplained Weight Changes** | | | | |
| **Fever** | | | | |

| Head & Neck | | | |
|---|---|---|---|
| | **Yes** | **No** | **Explain (if necessary)** |
| **Vision changes** | | | |
| **Routine eye exam** | | | |
| **Glasses/Contacts/Surgery** | | | **Specify:** |
| **Routine Dental Exams** | | | |
| **Ear/hearing changes** | | | |
| **Other** | | | |

| Breathing (Lungs) | | | |
|---|---|---|---|
| | Yes | No | Explain (if necessary) |
| Shortness of breath | | | |
| Wheezing | | | |
| Coughing | | | |
| Other | | | |
| **Circulation (Heart and Legs)** | | | |
| | Yes | No | Explain (if necessary) |
| Chest, throat, jaw or upper back pain, pressure, ache or squeezing sensation with eating, climbing stairs or exercising | | | |
| Fast, irregular or skipped heart beats | | | |
| Shortness of breath sleeping at night | | | |
| Calf pain when walking | | | |
| Other | | | |
| **Digestive** | | | |
| | Yes | No | Explain (if necessary) |
| Abdominal Pain | | | |
| Heartburn | | | |
| Pain/choking with swallowing | | | |
| Black tarry stools | | | |
| Regular Bowel Movements | | | _____ times per day or week |
| | | | |
| Other | | | |

| Bladder, Kidney, Prostate | | | |
|---|---|---|---|
| | Yes | No | Explain (if necessary) |
| Burning when urinating | | | |
| Rush to urinate or excessive urination | | | |
| Get up at night to urinate | | | |
| Urine leakage while coughing or sneezing | | | |
| Other | | | |

| Nervous System | | | |
|---|---|---|---|
| | Yes | No | Explain (if necessary) |
| Weakness on one side of body | | | |
| Numbness | | | |
| Headaches | | | |
| Forgetfulness | | | |
| Concentration Problems | | | |
| Other | | | |
| **Muscle and Joints** | | | |
| | Yes | No | Explain (if necessary) |
| Joint pain or swelling | | | |
| Muscle pain | | | |
| Other | | | |
| | | | |
| **Skin** | | | |
| | Yes | No | Explain (if necessary) |
| Unexplained Rash | | | |
| New or changing moles | | | |
| Other | | | |
| **Emotional** | | | |
| | Good | Poor | Explain (if necessary) |
| Happiness | | | |
| Calmness | | | |
| Other | | | |
| **Family History (Your Parents, Grandparents, Siblings)** | | | |
| | Yes | No | Explain (if necessary) |
| Cancer | | | |
| Stroke under the age of 60 | | | |
| Heart attack under the age of 60 | | | |
| Other diseases under 60 | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

| Men Only | | | |
|---|---|---|---|
| | **Yes** | **No** | **Explain (if necessary)** |
| **Difficulty in producing an erection** | | | |
| **Breast Lump** | | | |
| **Abnormal testicle mass** | | | |
| **Testicular Self Exam** | | | |
| | | | |
| **Other** | | | |
| **Women Only** | | | |
| | **Yes** | **No** | |
| **Menopause** | | | **If yes, hot flashes? Vaginal burning?** |
| | **Regular** | **Irregular** | |
| **Periods** | | | **Average pads per day:** |
| **How many days between periods** | _____ days | | **Period length:** ____ days |
| **1st Day of Last Normal Period** | | | |
| | **Yes** | **No** | **Explain** |
| **Cramps** | | | |
| **Abnormal Vaginal Discharge** | | | |
| **Abnormal Paps before** | | | |
| **Contraception** | | | |
| **Breast Lump** | | | |
| **Mammogram (Over 49 yr)** | | | |
| **Skin redness or textural abnormalities** | | | |
| **Regular Self Breast Exams** | | | |
| **Past Breast Feeding** | | | |
| **Other** | | | |