Patient: ______________________ Date: ____________

Patient Instructions: Please check any condition that you have ever had in the past or that you are currently experiencing, that you consider to be SIGNIFICANT.

1.	General	☐ Fever ☐ Weight loss ☐ Weight gain	☐ Chills ☐ Fatigue ☐ Sweats	☐ Sleep Disturbances ☐ Change in daily routines ☐ Nausea
2.	Head	☐ Headache ☐ Trauma	☐ Dizziness ☐ Loss of consciousness	☐ Other
3.	Eyes	☐ Contacts ☐ Glasses ☐ Cataracts	☐ Blurry vision ☐ Flashes in front of eyes ☐ Spots in front of eyes	☐ Double vision ☐ Sensitive to lights ☐ Other
4.	Ears	☐ Ringing in ears ☐ Frequent infections	☐ Hearing loss ☐ Drainage	☐ Pain ☐ Other
5.	Nose	☐ Post-nasal drip ☐ Sinus	☐ Nosebleeds	☐ Other
6.	Mouth	☐ Gum bleeds ☐ Dentures ☐ Changes in taste	☐ Cold sores ☐ Difficulty swallowing ☐ Sore throat	☐ Jaw pain ☐ Swelling ☐ Other
7.	Neck	☐ Masses ☐ Swelling	☐ Stiffness	☐ Other
8.	Lungs	☐ Asthma ☐ Cough ☐ Tuberculosis	☐ Pneumonia ☐ Coughing up sputum ☐ Coughing up blood	☐ Wheezing ☐ Difficulty breathing
9.	Vascular	☐ Chest pain ☐ Palpitations ☐ High blood pressure	☐ Swelling ☐ Leg cramps ☐ Low blood pressure	☐ Calf pain ☐ Ankle swelling ☐ Varicose veins
10.	Gastro-Intestinal	☐ Gas ☐ Diarrhea ☐ Digestion	☐ Vomiting ☐ Constipation ☐ Abdominal pain	☐ Heartburn ☐ Blood in stool ☐ Hemorrhoid
11.	Urinary	☐ Difficulty with urination ☐ Pain with urination ☐ Blood in urine	☐ Increased urination ☐ Decreased urination ☐ Incontinence	☐ Foul odor of urine ☐ Urinary tract infections
12.	Skin	☐ Rash ☐ Bruising ☐ Hair loss	☐ Warts ☐ Brittle nails ☐ Changes in moles	☐ Itching ☐ Other
13.	Neurology	☐ Seizures ☐ Strokes	☐ Tingling sensation ☐ Numbness	☐ Weakness ☐ Difficulty walking
14.	Musculo-Skeletal	☐ Joint pain ☐ Stiffness ☐ Muscle ache	☐ Arthritis ☐ Deformities ☐ Bone pain	☐ Fractures ☐ Dislocations
15.	Psychiatric	☐ Depression	☐ Mood swings	☐ Anxiety
16.	Diagnosed Medical Condition	☐ Hypertension ☐ Diabetes ☐ Thyroid Condition	☐ Heart Condition ☐ Rheumatoid Arthritis ☐ Epilepsy	☐ Alcoholism ☐ Cancer / Tumor ☐ Other
17.	Current Medication	☐ Prescribed ☐ Allergies	☐ Recreational drugs	☐ Self-medicated (i.e. aspirin. Motrin)
18.	Past Medical History	☐ Surgery - any area ☐ Hospitalization	☐ History of medications ☐ Prescribed	☐ Substance Abuse
19.	Social History	☐ Consume Alcohol ☐ Smoker Past or Present	☐ Exercise regularly ☐ Consume Coffee	☐ Consume Teas ☐ Consume Soft Drinks
20.	Female Only OB-GYN	☐ Hysterectomy ☐ Pregnancy past/present ☐ Age period began:	☐ PMS ☐ Last PAP date: ☐ Breast Exam date:	☐ Lumps in breast ☐ Mastectomy ☐ Discharge from nipple

I have completed the above survey to the best of my ability. Signature: ______________________