PRESENT HEALTH STATUS REVIEW FORM: Please check all items that pertain you you.

Patient Name: ___________________________ DOB: ___________ Male ___ Female ___

Are you currently, or have you recently experienced any problems or symptoms as described below?

Constitutional __weight gain; __weight loss; __appetite increase; __appetite decrease; __sleep problems; __fever: __chills; __decrease in energy; __night sweats

Neurological __headache; __seizure; __involuntary movements; __tremor; __fainting; __weakness; __dizziness; __numbness; __tingling sensation; __migraines; __balance problems; __stiffness

Endocrine __heat intolerance; __cold intolerance; __thyroid problems; __hair loss; __increased hairiness; __increased thirst/increased frequency of urination

Gastrointestinal __yellowing skin; __abdominal swelling; __nausea; __vomiting; __blood in stool; __dark tarry stool; __diarrhea/constipation; __pain in abdomen; __heartburn; __blood in vomit

Genitourinary __blood in urine; __change in urine color; __painful urination; __menstrual problems; __pain in testicles; __sexual dysfunction; __vaginal discharge; __penis discharge

Eye __pain; __blurry vision; __excessive tearing; __decreased vision

Ear, Nose, Throat __ear ache; __nosebleeds; __decreased hearing; __ringing in ears; __trouble swallowing; __sinus problems; __vertigo; __sore tongue; __hoarseness; __sore throat; __sore gums; __tooth ache

Cardiovascular __chest pain; __shortness of breath; __heart racing; __lightheadedness; __high blood pressure; __swelling of legs

Respiratory __cough; __sputum production; __blood in sputum; __chest pain when breathing; __wheezing; __shortness of breath

Musculoskeletal __neck or back pain; __pain in joints; __problem with gait; __pain in muscles

Skin/Breasts __rash; __lumps; __sores; __itching; __increased lactation; __discharge from nipples

Hematologic & Lymphatic __swollen lymph nodes; __bleeding problems; __blood clotting disorder

Allergic & Immunologic __arthritis; __eczema; __hay fever; __asthma; __runny nose; __congestion

Any other symptoms or health con terns, please list and address here (use back of form if necessary):

ESign
Patient Signature_____________________________________ Date___________________