Patient Name _____ Date of Birth _____ Date of Service _____

Please answer yes or no to the following:

Gastrointestinal

Poor Appetite	___No	___Yes
Difficulty in swallowing	___No	___Yes
Heartburn	___No	___Yes
Nausea	___No	___Yes
Vomiting	___No	___Yes
Bloating	___No	___Yes
Belching	___No	___Yes
Regurgitation	___No	___Yes
Constipation	___No	___Yes
Diarrhea	___No	___Yes
Abdominal pain	___No	___Yes
Recent change in bowel habit	___No	___Yes
Rectal Bleeding	___No	___Yes
Black, tarry stools	___No	___Yes
Rectal Pain	___No	___Yes

Constitutional

Recent Weight Change	___No	___Yes
Fever	___No	___Yes
Fatigue	___No	___Yes

Eyes

Blurred Vision	___No	___Yes
Glaucoma	___No	___Yes

Ears/Nose/Mouth/Throat

Hearing Loss	___No	___Yes
Ringing in Ears	___No	___Yes
Mouth Sores	___No	___Yes

Cardiovascular

Chest Pain	___No	___Yes
Shortness of breath	___No	___Yes
Swelling of ankles	___No	___Yes

Respiratory

Chronic cough	___No	___Yes
Spitting up Blood	___No	___Yes
Wheezing	___No	___Yes

Genitourinary

Burning with urination	___No	___Yes
Blood in urine	___No	___Yes

Skin

Rash	___No	___Yes
Itching	___No	___Yes

Neruological

Headaches	___No	___Yes
Seizures	___No	___Yes
Strokes	___No	___Yes
Numbness	___No	___Yes

Psychiatric

Memory loss or confusion	___No	___Yes
Depression	___No	___Yes

Endocrine

Heat or cold intolerance	___No	___Yes
Excessive thirst or urination	___No	___Yes

Hematological

Bleeding or bruising tendency	___No	___Yes
Anemia	___No	___Yes
Past transfusion	___No	___Yes

Are you pregnant	___No	___Yes

I verify that the information on this form is correct. Patient Signature:_____

Physicians Comments _____