NAME: ______________________________ DOB: ______________________

PLEASE CIRCLE ANY OF THE FOLLOWING YOU HAVE HAD SINCE YOUR LAST VISIT:

CONSTITUTIONAL	EYES	GASTROINTESTINAL	ENDOCRINE
Fever Chills Weight Loss/Gain Weakness	Blurred Vision	Heartburn Nausea Vomiting Abdominal Pain Diarrhea Constipation Bloody Stools Black, Tarry Stool (Melena)	Easy Bruise/bleed
SKIN	**CARDIOVASCULAR**	**GENITOURINARY**	**NEUROLOGICAL**
Rash	Chest Pain Palpitations Leg Swelling	Painful Urination (Dysuria) Urgency Blood in Urine (Hematuria)	Dizziness Tremors Sensory Change Focal or Temporary Weakness Seizures Loss of Consciousness (LOC)
HENT	**RESPIRATORY**	**MUSCULOSKELETAL**	**PSYCHIATRIC**
Headaches Hearing Loss Nosebleeds	Cough Sputum Production Shortness of Breath Wheezing	Muscle Pain (Myalgia) Joint Pain	Depression Suicidal Ideas Substance Abuse Nervous/Anxious Memory Loss

If you have been waiting longer than 30 minutes, please inform receptionist. Thank you.