Institute for Exercise and Environmental Medicine

Texas Health Presbyterian Hospital DALLAS | UT Southwestern Medical Center

Date: _____

Name: _____

DOB: _____

1. What is the reason for your visit today? _____
2. Local Pharmacy and Phone (if changed since last visit) _____
3. Have you seen any physicians since your last visit? ☐ Yes ☐ No

   If yes,

   a. Where: _____

   b. When: _____
4. Have you been in the hospital since your last visit? ☐ Yes ☐ No

   If yes,

   a. Where: _____

   b. When: _____

Please check if you have any of the following symptoms listed below:

CONSTITUTION	EYES	GASTROINTESTINAL	ENDO/HEME/ALL
☐ Chills	☐ Blurred Vision	☐ Heartburn	☐ Easy Bruising
☐ Weight Loss	☐ Double Vision	☐ Nausea	☐ Allergies
☐ Fatigue	☐ Sensitive to Light	☐ Vomiting	☐ Excessive Thirst
☐ Sweating or Perspiration	☐ Tunnel Vision	☐ Abdominal Pain	**NEUROLOGICAL**
☐ Weakness	☐ Blackouts	☐ Diarrhea	☐ Dizziness
SKIN	☐ Spots in Vision	☐ Constipation	☐ Tingling
☐ Rash	**HENT**	☐ Blood in Stool	☐ Tremor
☐ Itching	☐ Headaches	☐ Black Stool	☐ Sensory Change
CARDIOVASCULAR	☐ Hearing Loss	**GENITOURINARY**	☐ Speech Change
☐ Chest Pain	☐ Ringing in the Ears	☐ Painful Urination	☐ Focal Weakness
☐ Palpitations or Flutters	☐ Loss of Smell	☐ Urgency	☐ Seizures
☐ Leg Swelling	☐ Loss of Taste	☐ Urinary Frequency	☐ Loss of Consciousness
☐ Leg Pain while Walking	☐ Congestion	☐ Blood in Urine	**PSYCHIATRIC**
☐ Shortness of Breath When Lying Down	☐ Sore Throat	☐ Flank Pain	☐ Depression
	RESPIRATORY	**MUSCULOSKELETAL**	☐ Suicidal Ideas
☐ Waking from Sleep Short of Breath	☐ Cough	☐ Muscle Pain	☐ Substance Abuse
	☐ Coughing up Blood	☐ Neck Pain	☐ Hallucinations
	☐ Sputum Production	☐ Back Pain	☐ Nervous/Anxious
	☐ Short of Breath	☐ Joint Pain	☐ Insomnia
	☐ Wheezing	☐ Falls	☐ Memory Loss