Date:________________________________

Name:_______________________________

DOB:________________________________

1. What is the reason for your visit today?____
2. Local Pharmacy & Phone# (only if changed since last visit)____
3. Who is your primary care physician?_________________________ Last Visit:_______________________
4. Have you been in the hospital since your lst visit? NO YES
    a. If yes, where:____
    b. When:____

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

CONSTITUTION	EYES	GASTROINTESTIONAL	ENDO/HEME/ALL
Fever	Blurred Vision	Heartburn	Easy bruising
Chills	Double Vision	Nausea	Allergies
Weight loss	Sensitive to light	Vomiting	Excessive thirst
Fatigue	Eye Pain	Abdominal pain	NEUROLOGICAL
Sweating/Perspiration	Eye discharge	Diarrhea	Dizziness
Weakness	Eye redness	Constipation	Tingling
SKIN	CARDIOVASCULAR	Blood in stool	Tremor
Rash	Chest Pain	Black stool	Sensory change
Itching	Palpitations/flutters	GENITOURINARY	Speech change
HENT	Shortness of breath when lying down	Painful urination	Focal weakness
Headaches	Leg pain while walking	Urgency	Seizures
Hearing loss	Leg swelling	Urinary frequency	Loss of consciousness
Ringing in the ears	Waking from sleep short of breath	Blood in urine	PSYCHIATRIC
Ear Pain	RESPIRATORY	Flank pain	Depression
Ear Discharge	Cough	MUSCULOSKELETAL	Suicidal ideas
Nosebleeds	Coughing up blood	Muscle pain	Substance abuse
Congestion	Sputum production	Neck pain	Hallucinations
Sore throat	Short of breath	Back pain	Nervous/anxious
	Wheezing	Joint pain	Insomnia
		Falls	Memory loss