CURRENT MEDICAL REVIEW:
Please circle any current problems.

GENERAL
- weight loss or gain
- appetite loss or increase
- sleeping problems

NEUROLOGICAL AND PSYCHIATRIC
anxiety	depression	memory loss
headaches	dizziness	blackouts
weakness		
numbness or loss of sensation		

HEAD, EARS, EYES, NOSE, AND THROAT
vision change	wear glasses	eye draining
hearing loss	hearing aid	ear pain
runny nose	nose bleeds	sneezing
dentures	bad teeth	sore throat
bleeding gums		hoarseness
goiter or swollen glands		neck pain

RESPIRATORY
wheezing	cough	coughing blood
trouble breathing lying flat		

HEART AND BLOOD VESSELS
chest pain	palpitations
slow heart rate	cold hands/feet
rapid heart rate	leg pain with walking
awakening suddenly at night short of breath	

GASTROINTESTINAL
nausea/vomiting	stomach pain
constipation	diarrhea
hemorrhoids	black tarry stools
heartburn/indigestion	
bright red blood in bowel movements	

KIDNEYS AND URINARY TRACT
urgency to urinate	urinate often
painful to urinate	blood in urine
dark/brown urine	poor bladder control

MUSCLES AND BONES
muscle aches	joint pain
morning stiffness	joint swelling

If yes, which joints or muscles?

BLOOD
- easy bruising/bleeding
- swelling in one leg or arm

ENDOCRINE/GLANDS
weight loss or gain	always hot
increased loss of hair	always cold
increased urinating	increase thirst
increased appetite	breast changes
testicle changes	

ALLERGY/IMMUNOLOGY
watery eyes	wheezing
whelps or hives	sneezing
frequent infections	

SKIN
rashes	itching	dry skin
dandruff	nail changes	sores
new/large/changing moles		

FEMALES ONLY
vaginal discharge	painful intercourse
mood swings	hot flashes
PMS	
heavy/irregular menstrual cycles	

MALES ONLY
urinate often	erection problems
testicle pain/swelling	dribbling
difficulty starting to urinate	
groin pain or swelling with straining	

Is there any other information that you would like to discuss with the doctor?

Thank you for completing this form. The doctor will review this information with you during your office visit.

Name: ______________________________

Social Security Number: ______________________

Date of Birth: _________________________

Date of Exam: _________________________