

Name: _____

Date: _____

The Main Reason I am here is to check on my: sugar thyroid other _____

Otherwise, I feel just fine OR **I have been complaining of:** (Please Check ALL that Apply)

01. GENERAL:

- Cough
- Painful Urination
- Flushing of Face
- Fatigue
- Difficulty with Breathing
- Less Sex Drive
- Headache
- Sensitive to Heat
- Inability to have children
- Numbness
- Sensitive to Cold
- Wheezing
- Erection Problem
- Tingling
- Sweating
- Blood in Sputum
- Disturbance in Period

**06. STOMACH-
INTESTINE**

- Thirst
- Pregnant: ___ Weeks
- Weight Gain
- Delivered ___ months
- Weight Loss
- Appetite Increase
- Nursing
- Appetite Decrease

02. EYES:

- Blurred Vision
- Difficult to Swallow
- Leg Pain
- Painful Eye
- Heartburn
- Hand Pain
- Eye Bulge
- Belching
- Back Pain

03. ENT/MOUTH

- Hearing Less
- Vomiting
- Joint Swelling
- Loss of Smell
- Constipation
- Stiffness
- Dental Problems
- Diarrhea

- Sore Throat
- Too Much Gas
- Hoarse Voice
- Abdominal Pain

04. HEART:

- Chest Pain
- Sores (Ulcers)
- Cold Feet
- Nail Abnormality
- Heart Racing
- Urinary Frequency
- Leg Swelling
- Excess hair on the face
- Nighttime Urination
- Excess hair on the body
- Inability to Control Urine
- Falling of Scalp Hair
- Acne

05. CHEST:

08. MUSCLE-BONES

09. SKIN:

10. NERVES:

- Headache
- Dizziness
- Passing Out
- Seizure

11. PSYCHE:

- Nervousness
- Depression
- Forgetfulness
- Difficulty with Sleep
- Too Much Sleep

12. BREAST-HORMONES:

- Breast Discharge
- Breast Soreness
- Breast Swollen

13. BLOOD/ LYMPH:

- Easy Bruising
- Neck Swelling

14. ALLERGY:

- Allergies Other Than Medications
- Immune Deficiency

DO NOT WRITE BELOW THIS LINE

FOR OFFICE USE: ROOM # _____ MA _____ LABS: Imported Attached Not Done Not Ordered

WT: _____ HT: _____ BP: _____ / _____ P: _____ RESP: _____ BS#'S: Attached Imported None avail.