

Review Of Symptoms

ARE YOU CURRENTLY OR HAVE YOU EVER SUFFERED FROM ANY OF THE FOLLOWING
PLEASE CHECK YES OR NO AND USE THE NOTES AREA TO ADD ANY ADDITIONAL INFORMATION

<i>Cardiovascular Disease</i>	Yes	No	Notes
Hypertension (High B/P)			
Congestive Heart Failure (CHF)			
Ischemic Heart Disease (Heart Disease)			
Angina (Chest Pain)			
Peripheral Vascular Disease (Poor Circulation)			
Lower Extremity Edema (Leg Swelling)			
DVT \ Pulmonary Emboli (Blood Clots)			
Heart Attack			
Valvular Disease (Heart Murmur)			
Arrhythmias (Irregular Heart Beat)			
Varicose Veins			
Cellulitis \ Phlebitis			
<i>Metabolic Disease</i>	Yes	No	Notes
Glucose Metabolism Disease (Diabetes)			
Hyperlipidemia (High Cholesterol)			
Hyperuricemia (Gout)			
Thyroid Disease			
<i>Respiratory Disease</i>	Yes	No	Notes
Obstructive Sleep Apnea			
Obesity Hypoventilation Syndrome			
Pulmonary Hypertension			
Asthma			
COPD			
Emphysema			
Chronic Bronchitis			
Shortness of Breath on Exertion			
Sarcoidosis			
<i>Gastro-Intestinal Disease</i>	Yes	No	Notes
Gastro-Esophageal Reflux (GERD)			
Cholelithiasis (Gallbladder Disease)			
Liver Disease			
Ulcers			
H-Pylori			
Diverticulosis			
Irritable Bowel Disease			
Crohn's Disease			
Constipation			
Hemorrhoids			
<i>Musculoskeletal Disease</i>	Yes	No	Notes
Back Pain			
Musculoskeletal Disease			
Fibromyalgia			
Arthritis			
<i>Reproductive Disease</i>	Yes	No	Notes
PCOS (Polycystic Ovarian Syndrome)			
Menstrual Irregularities			

Review Of Symptoms

ARE YOU CURRENTLY OR HAVE YOU EVER SUFFERED FROM ANY OF THE FOLLOWING
PLEASE CHECK YES OR NO AND USE THE NOTES AREA TO ADD ANY ADDITIONAL INFORMATION

Psychosocial	Yes	No	Notes
Psychosocial Impairment (Need daily assistance)			
Depression			
Anxiety \ Bipolar \ Psychosis \ Personality Disorder			
Suicidal Thoughts			
Bulimia \ Anorexia			
Alcohol Use (How much \ often)			
Substance Abuse (Illegal \ Street Drugs)			
Tabacco Use (How much \ how long)			
Genitourinary Disease	Yes	No	Notes
Stress Urinary Incontinence			
Kidney Stones or Kidney Disease			
Frequent Urinary Tract Infections			
Urinary Retention			
Neurologic Disease	Yes	No	Notes
Pseudotumor Cerebri			
Frequent Headaches \ Dizziness			
Stroke \ TIA			
Neuropathy \ Numbness (Affecting what on body?)			
General / Other	Yes	No	Notes
Abdominal Hernia \ Past Hernia (Where?)			
Functional Status (Use Cane or Wheel Chair?)			
Abdominal Skin \ Pannus (Large Hanging Skin)			
Other Skin Disorders \ Problems (Please Specify)			
Autoimmune Disease (Lupus \ Multiple Sclerosis)			
Bleeding \ Clotting Disorders (Please Specify)			
Cancers (Please Specify)			
Infectious Disease (Hepatitis \ HIV \ Tuberculosis)			
Anemia (Iron Deficiency \ B-12 Deficiency)			

PLEASE GIVE US DETAILS OF ANY MAJOR ILLNESS OR MEDICAL PROBLEMS: _____

DATE: _____

PLEASE DO NOT WRITE BELOW THIS LINE (CHECK IF NORMAL X FOR ABNORMAL WITH DESCRIPTION)

Physical Assessment

OBESITY: _____

GENERAL: _____

HEENT: _____

CARDIAC: _____

PULMONARY _____

ABDOMINAL: _____

MUSC.-SKELETAL _____

SKIN _____

NEURO _____

OTHER: _____

DATE: _____

PHYSICIAN SIGNATURE: _____