Have you recently had any of the following: Circle "Y" (yes) or "N" (no); if in doubt, leave blank.

General		
Tire easily, weakness	Y	N
Marked weight change	Y	N
Night sweats	Y	N
Persistent fever	Y	N
Sensitivity to heat	Y	N
Sensitivity to cold	Y	N
Skin		
Eruptions (rash)	Y	N
Change in color	Y	N
Change in hair	Y	N
Change in nails	Y	N
Eyes		
Trouble seeing	Y	N
Eye pain	Y	N
Inflamed eyes	Y	N
Double vision	Y	N
Worn glasses/contacts	Y	N
Ears		
Loss of hearing	Y	N
Ringing in ears	Y	N
Discharge	Y	N
Nose		
Loss of smell	Y	N
Frequent colds	Y	N
Obstruction	Y	N
Excess discharge	Y	N
Nosebleeds	Y	N
Mouth		
Sore gums	Y	N
Soreness of tongue	Y	N
Dental program	Y	N
Throat		
Postnasal drainage	Y	N
Soreness	Y	N
Hoarseness	Y	N
Breast		
Lumps	Y	N
Discharge	Y	N
Cardio-Respiratory		
Cough, persisting	Y	N
Sputum (phlegm)	Y	N
Bloody sputum	Y	N
Wheezing	Y	N
Chest pain/discomfort	Y	N
Pain on breathing	Y	N
Shortness of breath	Y	N
Difficulty breathing while lying down	Y	N
Swelling ankles	Y	N
Bluish fingers or lips	Y	N
High blood pressure	Y	N
Palpitations	Y	N
Vein trouble	Y	N

Digestive System Indicate average food selection each meal:

Breakfast ______________________________

Lunch______________________________

Dinner ______________________________

Change in appetite	Y	N
Difficulty swallowing	Y	N

Digestive System (cont.)		
Heartburn	Y	N
Abdominal distress	Y	N
Belching or excess gas	Y	N
Abdominal enlargement	Y	N
Nausea	Y	N
Vomiting	Y	N
Vomiting of blood	Y	N
Rectal bleeding	Y	N
Tarry stools	Y	N
Dark urine	Y	N
Jaundice	Y	N
Constipation	Y	N
Diarrhea	Y	N
Hemorrhoids	Y	N
Need for laxatives	Y	N
Genitourinary System		
Increase in frequency of urination (day)	Y	N
Increase in frequency of urination (night)	Y	N
Feel need to urinate without much urine	Y	N
Unable to hold urine	Y	N
Pain or burning	Y	N
Blood in urine	Y	N
Impotence	Y	N
Lack of sex drive	Y	N
Pain with intercourse	Y	N
Endocrine		
Thyroid trouble	Y	N
Adrenal trouble	Y	N
Cortisone treatment	Y	N
Diabetes	Y	N
Musculoskeletal		
Muscle cramps	Y	N
Muscle weakness	Y	N
Pain in joints	Y	N
Swollen joints	Y	N
Stiffness	Y	N
Deformity of joints	Y	N
Nervous System		
Headaches	Y	N
Dizziness	Y	N
Fainting	Y	N
Convulsions or fits	Y	N
Nervousness	Y	N
Sleeplessness	Y	N
Depression	Y	N
Change in sensation	Y	N
Memory loss	Y	N
Poor coordination	Y	N
Weakness or paralysis	Y	N

GYN-OB

Started menstruating at age ____ Date of last PAP test ________

Abnormal PAP (date) _________ Treatment ____________

Interval between periods _____ days Period length _____ days

Flow: light normal heavy Pain with periods: yes no

Date of last period (1st day) ______________________

Number of pregnancies _______ Number of miscarriages _____

Number of births ______________________

Physician's Signature ______________________________ Date ____________________