PATIENT HISTORY QUESTIONNAIRE

REVIEW OF SYSTEMS: (PLEASE CIRCLE YES OR NO)

CONSTITUTIONAL			**EARS/NOSE/THROAT/MOUTH**		
Good General Health	YES	NO	Hearing Loss/Ringing	YES	NO
Recent Weight Change	YES	NO	Sinus Problems	YES	NO
Night Sweats/Fevers	YES	NO	Nose Bleeds	YES	NO
Fatigue	YES	NO	Sore Throat/Voice Change	YES	NO
CARDIOVASCULAR			**RESPIRATORY**		
Chest Pain	YES	NO	Shortness of Breath	YES	NO
Palpitations	YES	NO	Cough	YES	NO
Heart Trouble	YES	NO	Wheezing/Asthma	YES	NO
Swelling Hands/Feet	YES	NO	Coughing up Blood	YES	NO
MUSCULOSKELETAL			**NEUROLOGICAL**		
Muscle Pain/Cramps	YES	NO	Frequent Headaches	YES	NO
Stiffness/Swelling Joints	YES	NO	Paralysis or Tremors	YES	NO
Joint Pain	YES	NO	Convulsions/Tremors	YES	NO
Trouble Walking	YES	NO	Numbness/Tingling	YES	NO
ENDOCRINE			**HEMATOLOGIC/LYMPHATIC**		
Excessive Thirst/Urination	YES	NO	Bruise Easily	YES	NO
Thyroid Disease	YES	NO	Slow to Heal	YES	NO
Hormone Problems	YES	NO	Enlarged Glands	YES	NO
GENITO-URINARY			**EYES**		
Blood in Urine	YES	NO	Wear Glasses/Contacts	YES	NO
Kidney Stones	YES	NO	Eye Disease/Injury	YES	NO
Difficulty Urinating	YES	NO	Glaucoma	YES	NO
Incontinence Problems	YES	NO			
			INTEGUMENTARY (SKIN)		
GASTRO-INTESTINAL			Change in Hair or Nails	YES	NO
Nausea/Vomiting	YES	NO	Rashes or Itching	YES	NO
Abdominal Pain	YES	NO			
Rectal Bleeding	YES	NO	**PSYCHIATRIC**		
Bowel Problems	YES	NO	Insomnia	YES	NO
			Confusion/Memory	YES	NO
ALLERGIES			Depression	YES	NO
Food Allergies	YES	NO			
Drug Allergies	YES	NO			

Please List:_____

PATIENT STATEMENT: To the best of my knowledge the above information is complete and accurate.

Signed: _____ Date: _____