Medical History Questionnaire

SYSTEM REVIEW: Check only symptoms that you have had in the last 3 months. If not applicable, please check N/A.

General Health

- ☐ Unexplained Weight loss
- ☐ Appetite change
- ☐ Fever
- ☐ Chills
- ☐ Extreme Fatigue
- ☐ N/A

Eyes:

- ☐ Loss of vision
- ☐ Double vision
- ☐ Pain
- ☐ Discharge
- ☐ Itching
- ☐ N/A

Ears, Nose, Mouth, Throat (problems other than current visit)

- ☐ Hearing loss
- ☐ Ear ringing
- ☐ Ear ache
- ☐ Ear drainage
- ☐ Dizziness
- ☐ Nasal discharge
- ☐ Sneezing
- ☐ Stuffy nose
- ☐ Nose bleed
- ☐ Difficulty chewing
- ☐ Difficulty swallowing
- ☐ Pain with swallowing
- ☐ Sore throat
- ☐ Facial pain/paralysis
- ☐ Hoarseness
- ☐ Lump in neck
- ☐ Mouth growth/ulcer/bleed
- ☐ Snoring
- ☐ N/A

Heart, Veins, Arteries (Cardiovascular):

- ☐ Chest pain
- ☐ Irregular heartbeat
- ☐ N/A

Respiratory:

- ☐ Wheezing
- ☐ Cough
- ☐ Coughing up blood
- ☐ Shortness of breath
- ☐ N/A

Stomach, Intestines (Gastrointestinal):

- ☐ Indigestion / heartburn
- ☐ Nausea/vomiting
- ☐ Abdominal pain
- ☐ Blood in stool
- ☐ N/A

Bones, Joints, Muscles (Musculoskeletal):

- ☐ Joint pain/ stiffness
- ☐ Neck pain
- ☐ Back pain
- ☐ Muscle spasms
- ☐ N/A

Skin (Integumentary)/Breast:

- ☐ New skin growths
- ☐ Rash
- ☐ Jaundice
- ☐ N/A

Neurological:

- ☐ Headaches
- ☐ Blackouts
- ☐ Seizures
- ☐ Paralysis
- ☐ Tingling/numbness
- ☐ N/A

Psychiatric:

- ☐ Insomnia
- ☐ Depression
- ☐ Anxiety
- ☐ N/A

Endocrine:

- ☐ Thyroid trouble
- ☐ Heat/cold tolerance
- ☐ Excessive thirst, hunger, urination
- ☐ N/A

Genitourinary/Gynocology:

- ☐ Painful urination
- ☐ Frequent urination
- ☐ Blood in urine
- ☐ Pregnant currently
- ☐ Menstruating
- ☐ N/A

Hematologic:

- ☐ Bleeding problems
- ☐ Easy bruising
- ☐ N/A

Discussions:

Patient Signature Date

APPT. LABEL (REQUIRED ON PAGE 1 ONLY)

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