

NAME: \_\_\_\_\_ DOB: \_\_\_\_\_

Review of Symptoms: Please indicate any personal history of currently active problems below:

• **CONSTITUTIONAL SYMPTOMS**

Good general health lately ..... Yes No
Recent weight change ..... Yes No
Fever/night sweats ..... Yes No
Fatigue/weakness ..... Yes No

• **EYES**

Eye disease or injury ..... Yes No
Glaucoma/cataracts ..... Yes No

• **EAR/NOSE/THROAT**

Problems with hearing ..... Yes No
Sore throat or voice change/swollen glands..... Yes No
Chronic Sinus Problem..... Yes No
Nose bleeds/mouth sores..... Yes No

• **CARDIOVASCULAR**

Heart trouble (murmur, rheumatic fever, valve disease, pacemaker)..... Yes No
Heart attack ..... Yes No
Artificial valve ..... Yes No
Chest pain or angina pectoris..... Yes No
Palpitation..... Yes No
Shortness of breath with walking or lying flat .... Yes No
Swelling of feet, ankles or hands..... Yes No
Poor circulation..... Yes No
High blood pressure ..... Yes No

• **RESPIRATORY**

Lung disease ..... Yes No
Shortness of breath ..... Yes No
Asthma or wheezing ..... Yes No

• **GASTROINTESTINAL**

Intestinal/stomach disease or colitis..... Yes No
Liver or gallbladder disease ..... Yes No
Abdominal Pain ..... Yes No
Peptic Ulcer (stomach or duodenal)..... Yes No

• **GENITOURINARY**

Bladder problems ..... Yes No
Kidney disease ..... Yes No
Problems with urination ..... Yes No
Kidney stones..... Yes No
Sexual difficulty ..... Yes No
Male - testicle pain/lumps..... Yes No
prostate problems..... Yes No
Female - irregular periods ..... Yes No
vaginal yeast infections ..... Yes No
estrogen replacement ..... Yes No
hysterectomy ..... Yes No
PREGNANT OR NURSING ..... Yes No
PLANNING A PREGNANCY ..... Yes No
current form of birth control.....
last menstrual period.....
age at onset of menopause.....

Please notify your doctor if you think you are pregnant or if you try to become pregnant because medications may need to be changed.

• **MUSCULOSKELETAL**

Joint pain ..... Yes No
Joint stiffness or swelling..... Yes No
Weakness of muscles or joints..... Yes No
Artificial joint ..... Yes No

• **INTEGUMENTARY (skin, breast)**

Problems with scarring or keloids..... Yes No
Ever been given Grenz ray or radiation therapy.... Yes No
Rash or itching ..... Yes No
Change in skin color..... Yes No
Change in hair or nails ..... Yes No
Varicose veins ..... Yes No
Breast pain ..... Yes No
Breast lump ..... Yes No
Breast discharge ..... Yes No

• **NEUROLOGICAL DISORDER**

Frequent or recurring headaches ..... Yes No
Light headed or dizzy ..... Yes No
Convulsions or seizures ..... Yes No
Stroke ..... Yes No

• **PSYCHIATRIC**

Nervousness ..... Yes No
Depression ..... Yes No
Other ..... Yes No

• **ENDOCRINE**

Glandular or hormone problem ..... Yes No
Thyroid disease ..... Yes No
Diabetes (insulin or non insulin - circle one) .... Yes No

• **HEMATOLOGIC/LYMPHATIC**

Taking any blood thinners now ..... Yes No
Slow to heal after cuts ..... Yes No
Bleeding or bruising tendency ..... Yes No
Anemia ..... Yes No
Phlebitis..... Yes No
Past transfusion..... Yes No
Blood or lymph gland disorder..... Yes No
Cancer or leukemia ..... Yes No

• **ALLERGIC/IMMUNOLOGIC/INFECTIOUS**

History of venereal disease (STD) ..... Yes No
History of HIV infection / AIDS..... Yes No
History of hepatitis..... Yes No
History of frequent infections..... Yes No
If Yes, where? \_\_\_\_\_

History of skin reaction or other adverse reaction to:
Local anesthesia ..... Yes No
Latex rubber ..... Yes No

Known food allergies: \_\_\_\_\_

Environmental allergies: \_\_\_\_\_

Any other health problem \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Reviewed by: \_\_\_\_\_

Date: \_\_\_\_\_