NAME ____________________ DATE______________

1. Chief Complaint: Symptoms? Are you BETTER, WORSE or UNCHANGED?

   a)

   b)

   c)

2. Since Your Last Visit: What Tests have been done? Results? Been Hospitalized? Yes No Why?

3. **COMPLETE MEDICATION LIST AT EACH VISIT** or LIST ALL CURRENT MEDICATIONS:

	Medications	Dosage	Frequency (how often)
1.			
2.			
3.			
4.			
5.			
6.			

4. Have you had NOW or RECENTLY any of the following: yes no Please check

NEURO	memory difficulty numbness or paralysis one side headache loss of coordination tingling dizziness ________
GENERAL	Weight gain or loss of___ lbs fever fatigue sleep problem ________
EYE	decreased vision R L double vision eye pain ________
ENT	swallowing problems hearing loss ringing in ears TMJ problem ________
RESP	shortness of breath cough congestion wheezing ________
CV	chest pain palpitation edema fainting ________
GI	nausea diarrhea cramps abdominal pain ________
GU	bladder infections loss of bladder control/wetting yourself trouble voiding prostate
GYN	new pregnancy menstrual problems started hormones breast problem ________
MUS-SKEL	joint pains neck pain back pain muscle cramps ________
SKIN	rash itching hair loss hair growth ________
PSYCH	hallucinations anxiety attacks panic attacks depressed confusion ________
ENDO	diabetes hypoglycemia low thyroid ________
HEME	bleeding bruising or swollen glands ________
ALLERGY	hayfever asthma frequent or unusual infections HIV or AIDS test ________

5. Any change in your smoking or drinking habits, marital status, job, family history Yes No