



Medical Information

PATIENT NAME: _____ **DATE:** _____

PLEASE CIRCLE ANY OF THE FOLLOWING THAT YOU EXPERIENCE:

- ENT:** Ear Pain, ear drainage, ringing, hearing loss, nasal congestion, nasal drainage, bleeding, sore throat, difficulty swallowing, neck pain, neck swelling
- Constitutional:** Fever, chills, weight loss
- Eyes:** Blurry vision, double vision, changes in vision acuity
- Cardiovascular:** Palpitations, chest pain, ankle swelling, leg cramping
- Respiratory:** Shortness of breath, coughing, wheezing, and coughing up blood
- GI:** Nausea, vomiting, diarrhea, constipation, heartburn, abdominal pain, dark or bloody stools
- GU:** Pain on urination, bloody urine, frequency or hesitancy of urination
- Musculoskeletal:** Joint, muscle or back pain
- Skin:** Rash, unusual lesions
- Neurological:** Dizziness, fainting spells, numbness, weakness, headache, stroke
- Psychological:** Depression, anxiety
- Endocrine:** Heat or Cold intolerance, weight change, increased thirst
- Hemo:** Easy bruising, bleeding
- Allergic:** Hives, hay fever
- Immunizations:** Hepatitis A__ Measles__ Tetanus__
Hepatitis B__ Pneumonia__ Varicella__
Influenza__ Rubella__