Please complete the following Medical Questionnaire

Review of Systems: (*Please check all that apply*)

Constitutional: ☐ Chills ☐ Fever ☐ Weight Loss ☐ Decline in Health ☐ Weakness
☐ Fatigue ☐ Weight Gain

Head: ☐ Dizziness ☐ Headaches ☐ Fainting ☐ Pain ☐ Head Injury ☐Sweats

Eyes: ☐ Blurry Vision ☐ Eye Pain ☐ Recent Injury ☐ Discharge ☐Eyeglass Use
☐ Unusual Sensations ☐ Double Vision ☐ Pain with Light ☐Vision Loss

ENT: ☐ Discharge (nose) ☐ Nasal Obstruction ☐ Discharge (ears) ☐ Pain (ears) ☐ Hay Fever

☐ Nosebleeds ☐ Hearing Aid ☐ Ringing in Ears ☐ Infections ☐ Sinus Infection ☐ Hearing Impairment

Respiratory: ☐ Asthma ☐ Bronchitis ☐ Pleurisy ☐ Short of Breath ☐ Cough ☐ Coughing Blood
☐ Positive TB Test ☐ Sputum ☐ Wheezing ☐ Wheezing ☐Pain ☐ Recent Chest X-Ray
☐ Tuberculosis

Cardiovascular: ☐ Chest Pain ☐ Heart Murmur ☐ Short of Breath-Exertion ☐ Palpitations
☐ High Blood Pressure ☐ Short of Breath-Lying Flat ☐ Extremity(s) Cool ☐ History of Heart Attack
☐ Thrombophlebitis

Gastrointestinal: ☐ Abdominal Pain ☐ Heartburn ☐ Hepatitis ☐ Constipation ☐ Excessive Hunger

☐ Nausea: ☐ Diarrhea ☐ Excessive Thirst ☐ Vomiting

Musculoskeletal: ☐Arthritis ☐Back Problems ☐Muscle Cramps ☐Restricted Motion ☐Joint Pain

☐ Deformities ☐ Muscle Stiffness ☐ Weakness ☐Gout ☐ Joint Stiffness ☐ Paralysis

Skin: ☐ Eczema ☐ Hives ☐ Itching ☐ Lumps ☐ Easy Bruising ☐ Skin Color Change

Neurological: ☐ Loss of Consciousness ☐ Dizziness ☐ Headaches ☐Strokes ☐ Blackouts ☐ Fainting

☐ Numbness ☐ Tingling ☐ Head Injury ☐ Burning ☐ Head Injury ☐ Paralysis ☐ Unsteady Gait

Patient Name:_____

Patient Date of Birth:_____ Today's Date_____