Please check if you have experienced any of the following since your last visit.

### GENERAL
- [ ] Weight gain
- [ ] Weight loss
- [ ] Fatigue
- [ ] Sweats
- [ ] Night sweats
- [ ] Fever
- [ ] Chills

### SKIN
- [ ] Rashes
- [ ] Itching
- [ ] Sores
- [ ] Hives
- [ ] Changing moles
- [ ] Hair loss

### EYES
- [ ] Glasses
- [ ] Blurring
- [ ] Double vision
- [ ] Spots
- [ ] Redness
- [ ] Pain
- [ ] Change in vision

### EARS
- [ ] Pain
- [ ] Decreased hearing
- [ ] Ringing noises
- [ ] Discharge

### NOSE & SINUSES
- [ ] Infections
- [ ] Bleeding
- [ ] Post-nasal drip
- [ ] Hay fever/allergy
- [ ] Trouble smelling

### MOUTH
- [ ] Dentures
- [ ] Gum problems
- [ ] Toothache
- [ ] Sore throats
- [ ] Hoarseness

### RESPIRATORY
- [ ] Wheezing
- [ ] Shortness of breath
- [ ] Cough
- [ ] Cough up blood

### CARDIOVASCULAR
- [ ] Chest pain
- [ ] Palpitations
- [ ] Irregular heartbeat
- [ ] Heart murmur
- [ ] Ankle swelling
- [ ] High blood pressure
- [ ] Trouble breathing when lying flat
- [ ] Wake up short of breath at night
- [ ] Pain in the calves when walking

### FEMALE
First day of last menstrual period: ___________________
- [ ] Still having periods
- [ ] Sexually active
- [ ] Irregular period
- [ ] Heavy periods
- [ ] Cramps / pain
- [ ] Missed periods
- [ ] Menopause symptoms
- [ ] Sexual function problems
- [ ] Vaginal discharge
- [ ] Spotting between periods
- [ ] Breast lump
- [ ] Breast pain
- [ ] Miscarriage
- [ ] Nipple discharge
- [ ] History of abnormal pap smear
- [ ] Pain with sex
- [ ] Current contraception: ____________________

### STOMACH & INTESTINES
- [ ] Change in appetite
- [ ] Indigestion
- [ ] Heartburn
- [ ] Pain
- [ ] Diarrhea
- [ ] Jaundice
- [ ] Constipation
- [ ] Hemorrhoids
- [ ] Hernia
- [ ] Vomiting blood
- [ ] Blood in stool
- [ ] Difficulty swallowing
- [ ] Nausea / vomiting
- [ ] Black tar-like stool
- [ ] Change in bowel habits

### BLOOD
- [ ] Easy bruising
- [ ] Bleeding tendency
- [ ] Anemia
- [ ] Blood transfusion (year _________)
- [ ] Breast pain
- [ ] Miscarriage
- [ ] Nipple discharge
- [ ] History of abnormal pap smear
- [ ] Pain with sex
- [ ] Current contraception: ____________________

### URINARY
- [ ] Frequent urination
- [ ] Painful urination
- [ ] Kidney stones
- [ ] Night urination
- [ ] Urgency
- [ ] Hard to start stream
- [ ] Blood in urine
- [ ] Slow or weak stream
- [ ] Leakage of urine

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Please turn page over →
<table>
<thead>
<tr>
<th>NERVOUS SYSTEM &amp; PSYCHOLOGICAL</th>
<th>GLANDULAR</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Headaches</td>
<td>□ Goiter</td>
</tr>
<tr>
<td>□ Anxiety</td>
<td>□ Thyroid problems</td>
</tr>
<tr>
<td>□ Suicidal thoughts</td>
<td>□ Heat intolerance</td>
</tr>
<tr>
<td>□ Seizures</td>
<td>□ Cold intolerance</td>
</tr>
<tr>
<td>□ Dizziness</td>
<td>□ High Blood Sugar</td>
</tr>
<tr>
<td>□ Numbness in any part of the body</td>
<td>□ Low Blood sugar</td>
</tr>
<tr>
<td>□ Weakness in any part of the body</td>
<td></td>
</tr>
<tr>
<td>Over the past 2 weeks, how often have you felt down,</td>
<td></td>
</tr>
<tr>
<td>depressed or hopeless?</td>
<td></td>
</tr>
<tr>
<td>□ Not at all</td>
<td>□ Several days</td>
</tr>
<tr>
<td>□ More than half the days</td>
<td>□ Nearly every day</td>
</tr>
<tr>
<td>Over the past 2 weeks, how often have you felt little</td>
<td></td>
</tr>
<tr>
<td>interest or pleasure in doing things?</td>
<td></td>
</tr>
<tr>
<td>□ Not at all</td>
<td>□ Several days</td>
</tr>
<tr>
<td>□ More than half the days</td>
<td>□ Nearly every day</td>
</tr>
<tr>
<td>□ Don’t feel safe at home or in your current relationship</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>MUSCLES &amp; JOINTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Painful joints</td>
</tr>
<tr>
<td>□ Joint swelling</td>
</tr>
<tr>
<td>□ Stiffness</td>
</tr>
<tr>
<td>□ Back pain</td>
</tr>
<tr>
<td>□ Gout</td>
</tr>
<tr>
<td>□ Weakness</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>HABITS / OTHER</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you use alcohol?</td>
</tr>
<tr>
<td>Type:________________________________</td>
</tr>
<tr>
<td>Are you currently a smoker?</td>
</tr>
<tr>
<td># of packs per day?________________________________</td>
</tr>
<tr>
<td>Are you a past smoker?</td>
</tr>
<tr>
<td># of packs per day?________________________________</td>
</tr>
<tr>
<td>Do you use chewing tobacco?</td>
</tr>
<tr>
<td># of cans per week?________________________________</td>
</tr>
<tr>
<td>Do you drink coffee?</td>
</tr>
<tr>
<td># of cups per day?________________________________</td>
</tr>
<tr>
<td>Have you ever used recreational drugs?</td>
</tr>
<tr>
<td>Types:________________________________</td>
</tr>
<tr>
<td>Do you exercise regularly?</td>
</tr>
<tr>
<td>Number of falls this year: ____________</td>
</tr>
<tr>
<td>Do you worry about falling?</td>
</tr>
<tr>
<td>Do you have an advanced healthcare directive or living</td>
</tr>
<tr>
<td>will?</td>
</tr>
</tbody>
</table>