

Below is a list of diseases that may seem unrelated to the purpose of your appointment.

However, these questions must be answered carefully as the problems can affect your overall course of care.

REVIEW OF SYMPTOMS - Please fill out all of the sections, even if "DENY"

CONSTITUTIONAL: <input type="checkbox"/> I DENY ANY CONSTITUTIONAL ISSUE(S)	<input type="checkbox"/> CHILLS	<input type="checkbox"/> WEIGHT GAIN	<input type="checkbox"/> WEIGHT LOSS	<input type="checkbox"/> FATIGUE	<input type="checkbox"/> NIGHT SWEATS	<input type="checkbox"/> DAYTIME SOMNOLENCE (DROWSINESS)	<input type="checkbox"/> FEVER
EYE/VISION: <input type="checkbox"/> I DENY ANY EYES/VISION ISSUE(S)	<input type="checkbox"/> BLINDNESS	<input type="checkbox"/> EYE PAIN	<input type="checkbox"/> TEARING	<input type="checkbox"/> FIELD CUTS (VISUAL FIELD DEFECT)	<input type="checkbox"/> CATARACTS	<input type="checkbox"/> CHANGE IN VISION	<input type="checkbox"/> WEAR GLASSES AND/OR CONTACT LENSES
EARS, NOSE AND THROAT: <input type="checkbox"/> I DENY ANY E/N/T ISSUE(S)	<input type="checkbox"/> BLEEDING	<input type="checkbox"/> FAINTING	<input type="checkbox"/> NASAL CONGESTION	<input type="checkbox"/> EAR DRAINAGE	<input type="checkbox"/> POST NASAL DRIP	<input type="checkbox"/> HOARSENESS	<input type="checkbox"/> RHINORRHEA (RUNNY NOSE)
	<input type="checkbox"/> DISCHARGE	<input type="checkbox"/> HEADACHES	<input type="checkbox"/> SINUS INFECTIONS	<input type="checkbox"/> EAR INFECTION(S)	<input type="checkbox"/> DIFFICULTY SWALLOWING	<input type="checkbox"/> SINUS INFECTIONS	<input type="checkbox"/> TMJ PROBLEMS
	<input type="checkbox"/> DIZZINESS	<input type="checkbox"/> LOSS OF SMELL	<input type="checkbox"/> DENTAL IMPLANTS	<input type="checkbox"/> HEARING LOSS	<input type="checkbox"/> EAR PAIN		
	<input type="checkbox"/> SNORING	<input type="checkbox"/> SORE THROATS (FREQUENT)	<input type="checkbox"/> TINNITUS (RINGING IN EARS)				
RESPIRATION: <input type="checkbox"/> I DENY ANY RESPIRATORY ISSUE(S)	<input type="checkbox"/> ASTHMA	<input type="checkbox"/> COUGHING UP BLOOD	<input type="checkbox"/> SPUTUM PRODUCTION	<input type="checkbox"/> COUGH	<input type="checkbox"/> SHORTNESS OF BREATH	<input type="checkbox"/> WHEEZING	
CARDIOVASCULAR: <input type="checkbox"/> I DENY ANY CARDIOVASCULAR ISSUE(S)	<input type="checkbox"/> ANGINA (CHEST PAIN OR DISCOMFORT)	<input type="checkbox"/> CHEST PAIN	<input type="checkbox"/> CLAUDICATION (LEG PAIN OR ACHINESS)	<input type="checkbox"/> HEART MURMUR	<input type="checkbox"/> HEART PROBLEMS	<input type="checkbox"/> ORTHOPNEA (DIFFICULTY BREATHING WHILE LYING DOWN)	<input type="checkbox"/> PALPITATIONS (IRREGULAR OR FORCEFUL BEATING OF THE HEART)
							<input type="checkbox"/> SWELLING OF LEGS
							<input type="checkbox"/> ULCERS
							<input type="checkbox"/> VARICOSE VEINS
GASTROINTESTINAL: <input type="checkbox"/> I DENY ANY GASTROINTESTINAL ISSUE(S)	<input type="checkbox"/> ABDOMINAL PAIN	<input type="checkbox"/> BELCHING	<input type="checkbox"/> BLACK, TARRY STOOLS	<input type="checkbox"/> CONSTIPATION	<input type="checkbox"/> DIARRHEA	<input type="checkbox"/> DIFFICULTY SWALLOWING	<input type="checkbox"/> HEARTBURN
							<input type="checkbox"/> HEMORRHOIDS
							<input type="checkbox"/> INDIGESTION
							<input type="checkbox"/> JAUNDICE (YELLOWING OF SKIN)
							<input type="checkbox"/> NAUSEA
							<input type="checkbox"/> RECTAL BLEEDING
							<input type="checkbox"/> ABNORMAL STOOL CALIBER (QUALITY)
							<input type="checkbox"/> ABNORMAL STOOL COLOR
							<input type="checkbox"/> ABNORMAL STOOL CONSISTENCY
							<input type="checkbox"/> VOMITING BLOOD
							<input type="checkbox"/> VOMITING
FEMALE: <input type="checkbox"/> I DENY ANY FEMALE ISSUE(S)	<input type="checkbox"/> BIRTH CONTROL THERAPY	<input type="checkbox"/> BREAST LUMP/PAIN	<input type="checkbox"/> BURNING URINATION	<input type="checkbox"/> CRAMPS	<input type="checkbox"/> FREQUENT URINATION	<input type="checkbox"/> HORMONE THERAPY	<input type="checkbox"/> IRREGULAR MENSTRUATION
							<input type="checkbox"/> URINE RETENTION
							<input type="checkbox"/> VAGINAL BLEEDING
							<input type="checkbox"/> VAGINAL DISCHARGE
MALE: <input type="checkbox"/> I DENY ANY MALE ISSUE(S)	<input type="checkbox"/> BURNING URINATION	<input type="checkbox"/> PROSTATE PROBLEMS	<input type="checkbox"/> ERECTILE DYSFUNCTION	<input type="checkbox"/> FREQUENT URINATION	<input type="checkbox"/> URINATION RETENTION		<input type="checkbox"/> HESITANCY/DRIBBLING
ENDOCRINE: <input type="checkbox"/> I DENY ANY ENDOCRINE ISSUE(S)	<input type="checkbox"/> COLD INTOLERANCE	<input type="checkbox"/> DIABETES	<input type="checkbox"/> EXCESSIVE APPETITE	<input type="checkbox"/> EXCESSIVE HUNGER	<input type="checkbox"/> EXCESSIVE THIRST	<input type="checkbox"/> FREQUENT URINATION	<input type="checkbox"/> GOITER
							<input type="checkbox"/> HAIR LOSS
							<input type="checkbox"/> HEAT INTOLERANCE
							<input type="checkbox"/> UNUSUAL HAIR GROWTH
							<input type="checkbox"/> VOICE CHANGES
SKIN: <input type="checkbox"/> I DENY ANY SKIN ISSUE(S)	<input type="checkbox"/> CHANGES IN NAIL TEXTURE	<input type="checkbox"/> CHANGES IN SKIN COLOR	<input type="checkbox"/> HAIR GROWTH	<input type="checkbox"/> HAIR LOSS	<input type="checkbox"/> HIVES	<input type="checkbox"/> PARESTHESIA (NUMBNESS, PRICKLING, OR TINGLING)	<input type="checkbox"/> RASH
							<input type="checkbox"/> SKIN LESIONS/ULCERS
							<input type="checkbox"/> HISTORY OF SKIN DISORDERS
							<input type="checkbox"/> VARICOSITIES
NERVOUS SYSTEM: <input type="checkbox"/> I DENY ANY NERVOUS SYSTEM ISSUE(S)	<input type="checkbox"/> DIZZINESS	<input type="checkbox"/> FACIAL WEAKNESS	<input type="checkbox"/> HEADACHES	<input type="checkbox"/> LIMB WEAKNESS	<input type="checkbox"/> LOSS OF CONSCIOUSNESS	<input type="checkbox"/> LOSS OF MEMORY	<input type="checkbox"/> NUMBNESS
							<input type="checkbox"/> SLEEP DISTURBANCE
							<input type="checkbox"/> STROKES
							<input type="checkbox"/> UNSTEADINESS OF GAIT
PSYCHOLOGIC: <input type="checkbox"/> I DENY ANY PSYCHOLOGIC SYSTEM ISSUE(S)	<input type="checkbox"/> ANHEDONIA (INABILITY TO EXPERIENCE JOY OR ENJOY LIFE)	<input type="checkbox"/> ANXIETY	<input type="checkbox"/> APPETITE CHANGES	<input type="checkbox"/> BEHAVIORAL CHANGE(S)	<input type="checkbox"/> BIPOLAR DISORDER	<input type="checkbox"/> CONFUSION	<input type="checkbox"/> CONVULSIONS
							<input type="checkbox"/> DEPRESSION
							<input type="checkbox"/> INSOMNIA
							<input type="checkbox"/> MEMORY LOSS
							<input type="checkbox"/> MOOD CHANGE(S)
ALLERGY: <input type="checkbox"/> I DENY ANY ALLERGY ISSUE(S)	<input type="checkbox"/> ANAPHYLAXIS (HISTORY OF SNEEZING)	<input type="checkbox"/> FOOD INTOLERANCE	<input type="checkbox"/> ITCHING	<input type="checkbox"/> NASAL CONGESTION	<input type="checkbox"/> SNEEZING		
HEMATOLOGY: <input type="checkbox"/> I DENY ANY HEMATOLOGIC ISSUE(S)	<input type="checkbox"/> ANEMIA	<input type="checkbox"/> BLEEDING	<input type="checkbox"/> BLOOD CLOTTING	<input type="checkbox"/> BLOOD TRANSFUSION(S)	<input type="checkbox"/> BRUISES EASILY	<input type="checkbox"/> FATIGUE	<input type="checkbox"/> LYMPH NODE SWELLING

PAST HEALTH HISTORY - Please fill out carefully as these problems can affect your overall course of care.

CHILDHOOD ILLNESS: <input type="checkbox"/> I DENY ANY CHILDHOOD ILLNESS(ES)	<input type="checkbox"/> ADD	<input type="checkbox"/> ALLERGIES/HAYFEVER	<input type="checkbox"/> ASTHMA	<input type="checkbox"/> ATOPIC DERMATITIS (ECZEMA)	<input type="checkbox"/> BED WETTING	<input type="checkbox"/> CEREBRAL PALSY	<input type="checkbox"/> CHICKEN POX	<input type="checkbox"/> DEPRESSION	<input type="checkbox"/> DIABETES	<input type="checkbox"/> EAR INFECTIONS	<input type="checkbox"/> FETAL DRUG EXPOSURE	<input type="checkbox"/> FOOD ALLERGIES	<input type="checkbox"/> HEADACHES	<input type="checkbox"/> HEPATITIS	<input type="checkbox"/> HIV	<input type="checkbox"/> MEASLES	<input type="checkbox"/> MUMPS	<input type="checkbox"/> RASH	<input type="checkbox"/> SCOLIOSIS	<input type="checkbox"/> SEIZURE DISORDER	<input type="checkbox"/> SICKLE CELL ANEMIA	<input type="checkbox"/> SPINA BIFIDA	<input type="checkbox"/> OTHER (PLEASE DESCRIBE)																	
ADULT ILLNESS: <input type="checkbox"/> I DENY ANY ADULT ILLNESS(ES)	<input type="checkbox"/> ALZHEIMERS	<input type="checkbox"/> ANEMIA	<input type="checkbox"/> ARTHRITIS	<input type="checkbox"/> ASTHMA	<input type="checkbox"/> CANCER	<input type="checkbox"/> CHICKEN POX	<input type="checkbox"/> CROHN'S/COLITIS	<input type="checkbox"/> CRPS (RSD)	<input type="checkbox"/> OTHER _____	<input type="checkbox"/> CVA (STROKE)	<input type="checkbox"/> CYSTIC KIDNEY DISEASE	<input type="checkbox"/> DEPRESSION	<input type="checkbox"/> DIABETES (INSULIN)	<input type="checkbox"/> DIABETES (NON INSULIN)	<input type="checkbox"/> EAR INFECTIONS (FREQUENT)	<input type="checkbox"/> EMPHYSEMA	<input type="checkbox"/> EYE PROBLEMS	<input type="checkbox"/> FIBROMYALGIA	<input type="checkbox"/> HEART DISEASE	<input type="checkbox"/> HEPATITIS	<input type="checkbox"/> HIV	<input type="checkbox"/> HYPERTENSION	<input type="checkbox"/> INFLUENZAL PNEUMONIA	<input type="checkbox"/> LIVER DISEASE	<input type="checkbox"/> LUNG DISEASE	<input type="checkbox"/> LUPUS ERYTHEMA (DISCOID)	<input type="checkbox"/> LUPUS ERYTHEMA (SYSTEMIC)	<input type="checkbox"/> MULTIPLE SCLEROSIS	<input type="checkbox"/> PARKINSON'S DISEASE	<input type="checkbox"/> PLEURISY	<input type="checkbox"/> PNEUMONIA	<input type="checkbox"/> PSYCHIATRIC PROBLEMS	<input type="checkbox"/> SCOLIOSIS	<input type="checkbox"/> SEIZURE DISORDER	<input type="checkbox"/> SHINGLES	<input type="checkbox"/> STD'S (UNSPECIFIED)	<input type="checkbox"/> SUICIDE ATTEMPT(S)	<input type="checkbox"/> THYROID PROBLEMS	<input type="checkbox"/> VERTIGO	<input type="checkbox"/> PAST HISTORY OF SIMILAR SYMPTOMS TO YOUR CURRENT CONDITION