

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"**

<b>CONSTITUTIONAL:</b> <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
<b>EYE/VISION:</b> <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
<b>EARS, NOSE AND THROAT:</b> <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)				
<b>RESPIRATION:</b> <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	
<b>CARDIOVASCULAR:</b> <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
<b>GASTROINTESTINAL:</b> <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
							<input type="checkbox"/> VOMITING BLOOD
<b>FEMALE:</b> <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
<b>MALE:</b> <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
<b>ENDOCRINE:</b> <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
<b>SKIN:</b> <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
<b>NERVOUS SYSTEM:</b> <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
<b>PSYCHOLOGIC:</b> <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"/> DEPRESSION
							<input type="checkbox"/> MEMORY LOSS
							<input type="checkbox"/> MOOD CHANGE(S)
							<input type="checkbox"/> CONVULSIONS
							<input type="checkbox"/> INSOMNIA
<b>ALLERGY:</b> <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		
<b>HEMATOLOGY:</b> <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.**

<b>CHILDHOOD ILLNESS:</b> <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)																
<b>ADULT ILLNESS:</b> <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"/> 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