SYMPTOMS REVIEW

Date: _____

PLEASE CHECK ANY SYMPTOMS YOU HAVE EXPERIENCED IN THE LAST 6 MONTHS

NEUROLOGICAL

- ☐ Blackout spells
- ☐ Dizziness
- ☐ Double vision
- ☐ Falls
- ☐ Headaches
- ☐ Imbalance
- ☐ Numbness
- ☐ Seizures
- ☐ Tingling

EARS, NOSE, THROAT, MOUTH

- ☐ Choking when eating
- ☐ Chronic cough ___dry __w/sputum
- ☐ Hoarseness
- ☐ Mouth ulcers
- ☐ Sinus congestion
- ☐ Sinus drainage
- ☐ Sore throat
- ☐ Trouble swallowing
- ☐ Voice change

GASTROINTESTINAL

- ☐ Abdominal pain
- ☐ Black stools
- ☐ Bloody stools
- ☐ Constipation
- ☐ Diarrhea
- ☐ Heartburn
- ☐ Nausea
- ☐ Vomiting

ENDOCRINE

- ☐ Excessive fatigue
- ☐ Excessive thirst
- ☐ Excessive urination
- ☐ Weight gain
- ☐ Weight loss

MUSCULOSKELETAL

- ☐ Joint pain
- ☐ Joint swelling
- ☐ Morning stiffness
- ☐ Muscle aches

CARDIOVASCULAR

- ☐ Ankle swelling
- ☐ Chest pain
- ☐ Palpitations

HEMATOLOGY

- ☐ Anemia
- ☐ Bleeding problems
- ☐ Blood clots
- ☐ Bruising

SKIN

- ☐ Bruises
- ☐ Rashes
- ☐ Ulcerations

GENITOURINARY

- ☐ Blood in urine
- ☐ Burning with urination
- ☐ Excessive urination

PSYCHIATRIC

- ☐ Anxiety
- ☐ Depression
- ☐ Memory loss

SLEEP: H/O sleep apnea Y___ N___

Do you snore? _____Y _____ N
Do you fall asleep easily during the day? ____Y___N
Do you ever awaken gasping for air? ___Y___N
Do you ever awaken with a choking sensation?
Have you fallen asleep while driving? ____Y_____N
How many hours a night do you sleep? _____ hrs
Has your partner left the bedroom due to your snoring? _____Y _____ N

Patient Signature _____ **Date**_____

MD/NP Signature _____ **Date** _____

Reviewed With Patient:

Changes: Y N _____**Initial** _____**Date**_____
Changes: Y N _____**Initial** _____**Date**_____
Changes: Y N _____**Initial** _____**Date**_____

PAST / FAMILY / SOCIAL HISTORY

DATE: _____ **PRIMARY CARE PHYSICIAN:** _____

Any Known Exposures to:

Asbestos _____Y _____N Tuberculosis _____Y _____N Silica _____Y _____N

Foreign Travel: ___Y ___N Location/Date_____

PNEUMOVAX

☐ Date _____

FLU SHOT

☐ Date _____

DRUGALLERGIES

_____

_____

_____

_____

PAST MEDICAL HISTORY

- ☐ None
- ☐ Angina
- ☐ Asthma
- ☐ Bleeding Disorder
- ☐ Bronchitis
- ☐ Cancer
- ☐ Diabetes
- ☐ Emphysema / COPD
- ☐ Heart Attack
- ☐ High Blood Pressure
- ☐ Pneumonia
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Vascular Disease
- ☐ GERD
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____

SURGICAL HISTORY

- ☐ None
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____

FAMILY MEDICAL HISTORY

Mother:_____

_____

_____

_____

Father _____

_____

_____

Siblings _____

_____

_____

_____

_____

_____

Children_____

_____

_____

_____

_____

SOCIAL HISTORY

- ☐ Married
- ☐ Divorced
- ☐ Single
- ☐ Widowed

SMOKING

Current___ PPD_____
Number of yrs._____

Former Smoker _____
Number of yrs._____
Quit Date _____

Never Smoked_____
Second Hand Smoke
Exposure Y N

How often do you have an alcoholic beverage? Daily_____ Weekly_____ Other_____

Patient Signature _____**Date**_____

MD/NP Signature _____ **Date** _____

Reviewed With Patient:

Changes: Y N _____**Initial** _____**Date**_____
Changes: Y N _____**Initial** _____**Date**_____
Changes: Y N _____**Initial** _____**Date**_____