Name:Date:		
Please check any boxes that are <u>current</u> problems you would like to discuss with the doctor. This sheet is <u>confidential</u> and is private informatio between you and your doctor. New patients should fill out completely. If this is a <u>past</u> condition, indicate date next to problem.		
Habits	Lungs	Gastrointestinal
☐ Smoke cigarettes or chewing tobacco	☐ Get excessively sleepy while driving	☐ Loss of appetite
☐ More than 2 alcoholic drinks daily	☐ Early morning headaches	☐ Difficulty swallowing
☐ Used recreational drugs	□ Blood clots	☐ Acid Reflux
☐ Don't exercise regularly	□ Asthma	☐ Heartburn or indigestion
Nutrition	☐ Snore loudly at night	☐ Food intolerance
☐ Like salt and salty foods	□ Emphysema/COPD	□ Nausea or vomiting
☐ Weight gain/ loss of >15 lbs in past 1 year	☐ Tuberculosis or exposure to TB	□ Vomiting of blood
☐ Regularly eat fast food, cakes, cookies	☐ Coughing up blood	☐ Ulcers
□ Would like help with diet	☐ Shortness of breath	☐ Abdominal pain
Blood & Lymphatic	☐ Pain with breathing	☐ Hepatitis/liver disease/jaundice
· -	☐ Stop breathing at night	☐ Gall bladder disease
☐ Frequent infections	- Stop oreasing at ingit	☐ Pancreatitis
☐ Have you had a blood transfusion	Cardiovascular	
□ Do you have anemia	☐ Wake up at night short of breath	
☐ Lumps in neck, armpits, or groin	☐ High cholesterol	☐ Blood in stools
Skin, Nails, & Hair	☐ Heart attack	☐ Black stools/Black tarry streaks in stoo
☐ Hair loss		☐ Family history of colon polyps
□ Nail Change	☐ Chest pressure, pain or tightness	☐ Family history of colon cancer
☐ Excessive itching	☐ Irregular heartbeat ☐ Shortness of breath on exertion	☐ Rectal pain
□ Dry Skin		☐ Hemorrhoids
□ Rash	☐ Can't sleep flat	☐ Stool incontinence
☐ Abnormal sore/mole/growth	☐ Urinate more than once after bedtime	
☐ Changing moles (color or shape)	☐ Ankles swell	Genitourinary
☐ Unwanted Birth Marks	☐ High blood pressure	☐ Kidney stones
☐ Unusual or Excess Hair Growth	☐ Do your feet get cold easily?	☐ Burning with urination
□ Acne	Neurological/Musculoskeletal	☐ Urinary frequency/urgency
Breasts	☐ Loss of consciousness	□ Blood in urine
☐ Nipple discharge/bleeding	☐ Memory loss/forgetfulness	☐ Difficulty starting urine
☐ Skin dimpling		☐ Infertility
□ Pain	□ Stroke	☐ Urine incontinence/Leaking
☐ Change in size	□ Numbness/tingling(location)	MALE
□ Lumps	□ Dizziness	☐ Impotence/ejaculatory problems
☐ Family history of breast Cancer	□ Back Pain	☐ Scrotal/testicle mass or enlargement
Sexuality	Other Pain	☐ Hernia
☐ Have Birth control needs	Prevention Year of most recent:	□ Prostate problems
□ Would like to discuss sexual concerns	□ Pap Smear	☐ Family history of prostate cancer
□ Worried about past sexuality	☐ Breast Exam	☐ Weak urine stream
□ Want HIV test	☐ Mammogram	☐ Penile lesion/discharge/STDs
	☐ Digital Rectal Exam	FEMALE
Haad	☐ Test for blood in stool	☐ Bleeding after menopause
Head	☐ Sigmoidoscopy	☐ Abnormal periods
☐ Have you had a severe head trauma	□ Colonoscopy	☐ Sores/lesions/STDs
☐ Severe headaches	☐ Bone density test	☐ Vaginal discharge/itching
□ Sinusitis	☐ TB Skin Test	☐ Pain with intercourse
□ Allergies	☐ Tetanus Immunization	☐ Abnormal pap smears
□ Visual loss	☐ Flu Shot	☐ Hot flashes
□ Double vision	☐ Hepatitis C test	☐ Bleeding after intercourse
☐ Hearing loss	☐ Pneumonia Shot	Psychiatric
☐ Voice hoarseness	□ PSA Prostate blood	☐ Mood problems
☐ Ringing in ears	☐ Cholesterol Test	☐ Anxiety
☐ Frequent nose bleeds	☐ Do you take an Aspirin daily?	☐ Concentration problems
☐ Lip/Gum/Mouth sores	☐ Vision Exam	☐ Suicidal thoughts
Neck	_ / ISION DAMIN	□ Need counseling
□ Stiffness		··· 6
□ Masses		
Are there any other medical problems not li	sted above you would like to discuss:	