

CONSTITUTIONAL

Hot Flashes _____
 Insomnia _____
 Anxiety _____
 Fever _____
 Unexplained Weight loss _____
 Unexplained weight gain _____
 Chills _____
 Fatigue _____

EYES

Blurred Vision _____
 Double Vision _____
 Glasses _____
 Cataracts _____
 Glaucoma _____

PULMONARY

Cough _____
 Sputum/Phlegm _____
 Shortness of Breath _____

EAR NOSE THROAT

Ear Aches _____
 Nasal Drainage _____
 Sore Throat _____

SKIN

Rashes _____
 Easily Bruised _____

NEUROLOGICAL

Frequent Headaches _____
 Blackouts _____
 Contusions _____
 Seizures _____

GASTRO INTESTINAL

Abdominal Pain _____
 Ulcers _____
 Black Bloody Stools _____

GASTRO URINARY

Problems Urinating _____
 Frequent urination _____
 Prostrate _____

CARDIAC

Heart Attack _____
 Murmurs _____
 Chest Pain _____

MUSKAL- SKELETAL

Back Pain _____
 Joint Pain _____
 Leg Pain _____
 Ankle Swelling _____

PAST MEDICAL HISTORY

Diabetes IDDM / NIDDM _____
 Hyperthyroidism _____
 Hypothyroidism _____

SOCIAL HISTORY

Smoke _____
 Alcohol _____

FAMILY HISTORY

Diabetes _____
 Heart Disease _____
 Cancer _____

DO YOU HAVE ANY OTHER HEALTH RELATED MATTERS WE SHOULD BE AWARE OF

DO YOU HAVE OR HAVE YOU EXPERIENCED ANY EMOTIONAL CHALLENGES WE SHOULD BE AWARE OF THAT COULD ADVERSELY IMPACT YOUR OVERALL HEALTH OR YOUR WEIGHT LOSS EFFORTS? MENTAL ILLNESS OR EATING DISORDERS?

ARE YOU EXPERIENCING MORE STRESS THAN USUAL? ARE YOU GENERALLY IN A HIGH STRESS ENVIRONMENT? HAVE YOU EXPERIENCED ANY LIFE-CHANGING EVENT THAT HAS CAUSED YOU TO EXPERIENCE ADDITIONAL STRESS OR GREIF?

Signature _____ Date _____