

PATIENT NAME IN FULL

M  
 F

DATE OF BIRTH

PLEASE CHECK THE APPROPRIATE BOX				•	Y = YES	N = NO	O = OCCASIONALLY						
<b>GENERAL</b>				<b>Y</b>	<b>N</b>	<b>O</b>	<b>RESPIRATORY</b>				<b>Y</b>	<b>N</b>	<b>O</b>
Persistent or unexplained tiredness							Breathless at rest						
Gained weight (how much?)							Breathless with exertion						
Lost weight (how much?)							Cough						
Trouble sleeping							Cough up sputum or phlegm						
Excessive daytime sleepiness							Cough up blood						
Lots of stress							Wheezing						
Persistent fever above 100.2°							Excessive snoring or long pauses of breathing during sleep						
Night Sweats							Date of last chest x-ray						
							Exposure to tuberculosis						
<b>EYES</b>				<b>Y</b>	<b>N</b>	<b>O</b>	Date of last tuberculosis skin test						
Had glaucoma							If done, was it positive						
Eye pain							<b>GASTROINTESTINAL</b>				<b>Y</b>	<b>N</b>	<b>O</b>
Vision trouble other than needing glasses							Heartburn						
Double vision							Vomiting						
Spots in vision							Vomiting blood						
Wear glasses or contacts or had vision surgery							Constipation						
Date of last eye exam							Hemorrhoids						
Any history of cataracts							Abdominal pain						
<b>EAR, NOSE AND THROAT</b>				<b>Y</b>	<b>N</b>	<b>O</b>	Diarrhea						
Changing hearing							Use laxatives						
Use of hearing aids							Blood in stools						
Ears ringing							Chalky white stools						
Sinus trouble							Narrow or ribbon-like stools						
Hoarseness							Black stools						
Lump in the throat							Hepatitis or jaundice in the past						
Painful or difficult swallowing							Date of last colonoscopy						
Use of dentures							<b>KIDNEYS AND BLADDER</b>				<b>Y</b>	<b>N</b>	<b>O</b>
Persistent or recurring sores in the mouth							Pain with urination						
<b>CARDIOVASCULAR</b>				<b>Y</b>	<b>N</b>	<b>O</b>	Urinate very frequently						
Chest pain or tightness							Get up at night to urinate						
Abnormal heart rhythm or palpitations							If so, how often						
Heart murmur							Trouble holding urine						
Leg cramps while walking							Bloody or discolored urine						
History of abnormal electrocardiogram							<b>MEN ONLY</b>				<b>Y</b>	<b>N</b>	<b>O</b>
Date of last electrocardiogram							Impotence or difficulty with erections						
Blue or very white fingers							Prostate trouble, difficult urination, or weak stream						
Wake up to catch breath							Sex with other men						
Sleep sitting up or propped up on pillows to breathe							Use of Viagra, Levitra or other E.D. medication						
Date of last stress test or other heart test													

