Recent Medical History

Check all of the boxes that apply to your health during the last ***six months***:

Constitutional

Loss of appetite	☐Yes	☐No
Unexplained tiredness	☐Yes	☐No
Prolonged fever	☐Yes	☐No
Night sweats	☐Yes	☐No
Weight loss	☐Yes	☐No
Weight gain	☐Yes	☐No

Ears/Nose/Throat

Buzzing or ringing in ears	☐Yes	☐No
Hearing loss	☐Yes	☐No
Ear pain	☐Yes	☐No
Do you wear hearing aids	☐Yes	☐No
Frequent nose bleeds	☐Yes	☐No
Pain/difficulty swallowing	☐Yes	☐No
Sore on lips or mouth	☐Yes	☐No
Dry mouth	☐Yes	☐No
Persistent sore throat	☐Yes	☐No
Persistent hoarse voice	☐Yes	☐No
Altered taste	☐Yes	☐No
Sinus problems	☐Yes	☐No

Eyes

Blurred vision	☐Yes	☐No
Double vision	☐Yes	☐No
Eye pain	☐Yes	☐No
Vision problems	☐Yes	☐No
Wear glasses/contacts	☐Yes	☐No

Gastrointestinal

Stomach pain or cramping	☐Yes	☐No
Nausea/vomiting	☐Yes	☐No
Heartburn	☐Yes	☐No
Ulcers	☐Yes	☐No
Change in bowel habits	☐Yes	☐No
Constipation	☐Yes	☐No
Diarrhea	☐Yes	☐No
Hemorrhoids	☐Yes	☐No
Black or tarry stools	☐Yes	☐No
Rectal bleeding	☐Yes	☐No

Skin

Changes in skin	☐Yes	☐No
Bruise easily	☐Yes	☐No
Persistent/recurring rash	☐Yes	☐No
Sores that won't heal	☐Yes	☐No
Itching	☐Yes	☐No

Urinary

Burning/painful urination	☐Yes	☐No
Trouble starting stream	☐Yes	☐No
Weak urinary stream	☐Yes	☐No
Urinating frequency	☐Yes	☐No
Frequent urination	☐Yes	☐No
Blood in urine	☐Yes	☐No
Urinary incontinence	☐Yes	☐No
Waking to urinate at night	☐Yes	☐No

Respiratory/Cardiovascular

Irregular/rapid heartbeat	☐Yes	☐No
Chest pain or angina	☐Yes	☐No
Ankle/leg swelling	☐Yes	☐No
Cough that persists	☐Yes	☐No
Painful cough	☐Yes	☐No
Shortness of breath	☐Yes	☐No
Cough up blood	☐Yes	☐No
Wheezing	☐Yes	☐No
Use supplemental oxygen	☐Yes	☐No

Musculoskeletal

Arthritis	☐Yes	☐No
Bone pain	☐Yes	☐No
Painful or swollen joints	☐Yes	☐No
Muscle weakness	☐Yes	☐No
Back pain	☐Yes	☐No
Limited range of motion	☐Yes	☐No

Do you use? Cane Walker Wheelchair

Neurological

Dizzy spells	☐Yes	☐No
Memory loss	☐Yes	☐No
Loss of balance	☐Yes	☐No
Frequent headaches	☐Yes	☐No
Insomnia	☐Yes	☐No
Numbness or tingling	☐Yes	☐No
Loss of strength	☐Yes	☐No
Changes in speech	☐Yes	☐No
Strokes	☐Yes	☐No
Seizures of tremors	☐Yes	☐No

Psychological

Feeling depressed	☐Yes	☐No
Feeling anxious	☐Yes	☐No
Mood swings	☐Yes	☐No

Patient name: _____ DOB: _____