Patient Name:_____ Date of Birth:_____

| *Respiratory* | *Circle One* | |
|---|---|---|
| Asthma | Yes | No |
| Chronic Cough | Yes | No |
| Emphysema | Yes | No |
| Shortness of Breath | Yes | No |
| Bronchitis | Yes | No |
| Pneumonia | Yes | No |
| Lung Cancer | Yes | No |
| Bloody Sputum | Yes | No |
| Date of Last Chest X-ray:_____ | Yes | No |

| *Gastrointestinal* | | |
|---|---|---|
| Indigestion or Pain With Eating | Yes | No |
| Nausea | Yes | No |
| Vomiting | Yes | No |
| Blood in Your Vomit | Yes | No |
| Liver Disease | Yes | No |
| Jaundice | Yes | No |
| Abdominal Pain | Yes | No |
| Change in Your Bowel Habits | Yes | No |
| Ulcers or Gastritis | Yes | No |
| Colon Cancer | Yes | No |

| *Genitourinary* | | |
|---|---|---|
| Urinary Tract Infections | Yes | No |
| Painful Urination | Yes | No |
| Blood in Your Urine | Yes | No |
| Difficulty Starting or Stopping Stream | Yes | No |
| Incontinence | Yes | No |
| Kidney Stones | Yes | No |
| Prostate Cancer (males) | Yes | No |
| Endometriosis (females) | Yes | No |
| Uterine or Cervical Cancer (females) | Yes | No |

| *Musculoskeletal* | | |
|---|---|---|
| Broken Bones---List:_____ | Yes | No |
| Arm or Leg Weakness | Yes | No |
| Back Pain | Yes | No |
| Arm or Leg Pain | Yes | No |
| Joint Pain or Swelling | Yes | No |
| Arthritis | Yes | No |