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