Patient Name:_____ Date of Birth:_____

	Circle One	
Integumentary		
Skin Disease	Yes	No
Skin Cancer	Yes	No
Breast Pain, Tenderness or Swelling (female)	Yes	No
Nipple Discharge (females)	Yes	No
Date and Result of Last Mammogram (females)	Yes	No
Neurological		
Fainting Spells or "Blacking Out"	Yes	No
Seizures	Yes	No
Problems with Your Memory	Yes	No
Disorientation	Yes	No
Neurological		
Difficulty with Your Speech	Yes	No
Inability to Concentrate	Yes	No
Double or Blurred Vision	Yes	No
Face Weakness	Yes	No
Coordination in Arm and/or Legs	Yes	No
Psychiatric		
Anxiety	Yes	No
Depression	Yes	No
Other Psychiatric Disorder/Treatment	Yes	No
Endocrine		
Diabetes	Yes	No
Thyroid Disease	Yes	No
Increased Appetite	Yes	No
Excessive Thirst or Urination	Yes	No
Hormone Problems	Yes	No
Hematologic/Lymphatic		
Anemia	Yes	No
Hemphophilia	Yes	No
Bleeding Tendencies	Yes	No
Persistent Swollen Glands or Lymph Nodes	Yes	No
Blood Transfusion	Yes	No
If yes, when?_____		
Allergic/Immunologic		
Food Allergies	Yes	No
Inhalant (nasal) Allergies	Yes	No
Immunologic Disorders	Yes	No