

Patient Name: _____ Date of Birth: _____

Integumentary

Circle One

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