

**PATIENT INFORMATION**

(First Name) \_\_\_\_\_ (Middle Name) \_\_\_\_\_ (Last Name) \_\_\_\_\_ Date of Birth \_\_\_\_\_  
 \_\_\_\_\_ Nick Name \_\_\_\_\_  
 (Street Address) \_\_\_\_\_ Social Security # \_\_\_\_\_  
 (City, State, Zip) \_\_\_\_\_  
 Home Phone ( ) \_\_\_\_\_ Cell Phone ( ) \_\_\_\_\_  Male  Female  
 Marital Status  Single  Married  Divorce  Widowed  
 Employer \_\_\_\_\_ Work Phone ( ) \_\_\_\_\_  
 Spouse's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
 Spouse's Employer \_\_\_\_\_ Work Phone ( ) \_\_\_\_\_  
 Emergency Contact (other than spouse) \_\_\_\_\_ Phone ( ) \_\_\_\_\_  
 Relationship \_\_\_\_\_ Primary Care Physician: \_\_\_\_\_

**GUARANTOR INFORMATION (If guarantor is the same as patient, omit this section)**

(First Name) \_\_\_\_\_ (Middle Name) \_\_\_\_\_ (Last Name) \_\_\_\_\_ Phone ( ) \_\_\_\_\_  
 (Street Address) \_\_\_\_\_ (City) \_\_\_\_\_ (State) \_\_\_\_\_ (Zip) \_\_\_\_\_

**INSURANCE INFORMATION (SUBSCRIBER)**

Primary Insurance \_\_\_\_\_ Policy # \_\_\_\_\_ Group # \_\_\_\_\_  
 If patient is insurance holder (subscriber) check here  and go to secondary plan, otherwise complete the following.  
 Subscriber Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
 Relationship to Patient \_\_\_\_\_ SS# \_\_\_\_\_  
 Address \_\_\_\_\_ Home Phone ( ) \_\_\_\_\_  
 Secondary Insurance \_\_\_\_\_ Policy # \_\_\_\_\_ Group # \_\_\_\_\_  
 If patient is insurance holder (subscriber) check here  otherwise please complete the following.  
 Subscriber Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
 Relationship to Patient \_\_\_\_\_ SS# \_\_\_\_\_  
 Address \_\_\_\_\_ Home Phone ( ) \_\_\_\_\_

**ADVANCED DIRECTIVE/LIVING WILL**

Do you have an Advanced Directive for Healthcare (Living Will)?  Yes  No  
 Are you aware that you have the right to have an Advanced Directive for Health Care?  Yes  No

**AUTHORIZATIONS / CONSENT FOR TREATMENT**

I hereby apply for treatment by the physicians of this practice and/or their assistants. I authorize the release of any information necessary to determine liability for payment and to obtain reimbursement on any claim. I request that payment of authorized benefits by made on my behalf and I assign the benefits payable to which I am entitled, including Medicare, private insurance and other health plans, to this practice. I understand that it is my responsibility to pay any deductible and/or co-pay amount, and that I am financially responsible for all charges whether or not paid by insurance. I have been informed that some lab studies may go to an outside lab, and I may receive a separate bill for these services. The practice is authorized to use my medical information in its quality assurance and utilization review programs.

By state law you must be advised that the information authorized for release may include records which may indicate the presence of a communicable or non-communicable disease.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**Patient History and Review of Systems**

Patient's Legal Name: \_\_\_\_\_ Date: \_\_\_\_\_  
 Primary Care Physician: \_\_\_\_\_ Referring Physician: \_\_\_\_\_

**Have you been diagnosed by a doctor with any of the following Active Problems?**

	When:	Treating Physician:		When:	Treating Physician:
<input type="checkbox"/> Angina	/ /		<input type="checkbox"/> Heart Failure	/ /	
<input type="checkbox"/> Aortic Aneurysm	/ /		<input type="checkbox"/> Heart Rhythm problem	/ /	
<input type="checkbox"/> Blood Clot(s)	/ /		<input type="checkbox"/> Heart Valve problem	/ /	
<input type="checkbox"/> Cardiomyopathy	/ /		<input type="checkbox"/> High Blood Pressure	/ /	
<input type="checkbox"/> Cirrhosis of liver	/ /		<input type="checkbox"/> High Cholesterol	/ /	
<input type="checkbox"/> COPD	/ /		<input type="checkbox"/> Kidney disease (chronic)	/ /	
<input type="checkbox"/> Coronary Artery disease	/ /		<input type="checkbox"/> Neck Artery blockage	/ /	
<input type="checkbox"/> Diabetes	/ /		<input type="checkbox"/> Peripheral Artery disease	/ /	
<input type="checkbox"/> Esophageal reflux	/ /		<input type="checkbox"/> Stroke	/ /	
<input type="checkbox"/> Heart Attack	/ /		<input type="checkbox"/> Transient Ischemic Attack	/ /	

**Any other Past Major Illnesses/Injuries/Treatments:** \_\_\_\_\_ Date: \_\_\_\_\_ Complications/Treatment/other Comments: \_\_\_\_\_

\_\_\_\_\_  
 / /  
 / /  
 / /

**Have you had any of the following:**

Diagnostic Test(s)	When:	Where:		When:	Where:
<input type="checkbox"/> EKG	/ /		<input type="checkbox"/> Heart Bypass Surgery	/ /	
<input type="checkbox"/> Stress test	/ /		<input type="checkbox"/> Heart Valve Surgery	/ /	
<b>Heart Rhythm Surgery:</b>			<input type="checkbox"/> Heart Transplant	/ /	
<input type="checkbox"/> Pacemaker	/ /		<input type="checkbox"/> Other Heart Surgery:	/ /	
<input type="checkbox"/> Defibrillator	/ /		<input type="checkbox"/> Lower Back Surgery	/ /	
<input type="checkbox"/> Ablation	/ /		<input type="checkbox"/> Upper Back Surgery	/ /	
<b>Angiogram of:</b>			<input type="checkbox"/> Appendectomy	/ /	
<input type="checkbox"/> Coronary Arteries	/ /		<input type="checkbox"/> Colon Surgery	/ /	
<input type="checkbox"/> Neck Arteries	/ /		<input type="checkbox"/> Gall Bladder Removal	/ /	
<input type="checkbox"/> Abdominal Aorta	/ /		<input type="checkbox"/> Hysterectomy	/ /	
<input type="checkbox"/> Legs/Arms	/ /		<input type="checkbox"/> Mastectomy Lt Rt Bi	/ /	
<b>Surgeries/Procedures:</b>			<input type="checkbox"/> Leg Angioplasty/Stent	/ /	
<input type="checkbox"/> Carotid Artery surgery	/ /		<input type="checkbox"/> Leg Bypass Surgery	/ /	
<input type="checkbox"/> Carotid Artery Stent	/ /		<input type="checkbox"/> Varicose Vein Surgery	/ /	
<input type="checkbox"/> Heart Balloon/Stent	/ /				

**Additional Major Surgeries or Diagnostic Procedures**      **Date**      **Complications/Treatment or other Comments**

\_\_\_\_\_ / \_\_\_\_ / \_\_\_\_

\_\_\_\_\_ / \_\_\_\_ / \_\_\_\_

\_\_\_\_\_ / \_\_\_\_ / \_\_\_\_

- Currently Pregnant
- Menopause - Symptomatic (such as hot flashes)
- Menopause has occurred

Pregnancy complication(s): \_\_\_\_\_

**Family History**

- Unobtainable Adopted/Orphaned       Father alive    DOB: \_\_\_\_\_       Mother alive    DOB: \_\_\_\_\_
- Father deceased       Mother deceased
- His cause of death: \_\_\_\_\_       Her cause of death: \_\_\_\_\_

**Father      Mother      Brother      Brother      Sister      Sister**

Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma/Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Cancer type:</i>						
Coronary Artery Disease < age 50	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coronary Artery Disease > age 50	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Failure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Rhythm Problem	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney/Bladder Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
MI - Acute (Heart attack)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Other:</i>						

**Social History**

**Do you now or have you ever used alcohol?**

\_\_\_\_\_ Cans/Bottles of Beer per week

\_\_\_\_\_ Glasses of Wine per week

\_\_\_\_\_ Drinks of Liquor per week

- Alcohol use
- In Moderation (≤ 2 per day)
- Never drank alcohol
- Recovering alcoholic
- Stopped drinking alcohol      when: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**Do you use caffeine?**       Do not use Caffeine

- Caffeine Use
- \_\_\_\_\_ Cups of Coffee/day
- \_\_\_\_\_ Cups/Glasses of Tea per day
- \_\_\_\_\_ Soft Drinks per day

**Have you ever used drugs?**

- Does not use drugs
- Drug Use
- Amphetamines       Heroin
- Barbiturates       LSD/Hallucinogens
- Cocaine       Marijuana

**Social History (continued)**

<p><b>What is your level of Education?</b></p> <input type="checkbox"/> Educational Level - Completed None <input type="checkbox"/> Educational Level - GED <input type="checkbox"/> Educational Level - Grades 1-6 <input type="checkbox"/> Educational Level - Grades 7-12 <input type="checkbox"/> Educational Level - Graduate (13+) <input type="checkbox"/> Educational Level - Postgraduate (17+) <input type="checkbox"/> Educational Level - Trade School	<p><b>Are you currently employed?</b></p> <input type="checkbox"/> Working Full Time <input type="checkbox"/> Not Currently Employed <input type="checkbox"/> Currently on Disability <input type="checkbox"/> Working Part Time <input type="checkbox"/> Retired from Work	<p><b>Ethnic/Cultural background?</b></p> <input type="checkbox"/> African-American/Black <input type="checkbox"/> Asian/Eastern-Asian Indian <input type="checkbox"/> Caucasian/White <input type="checkbox"/> Hawaiian/Pacific Islander <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Native American/Alaskan Native
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<p><b>What is your level of physical activity?</b></p> <input type="checkbox"/> Being Sedentary <input type="checkbox"/> Heavy Labor on Job <input type="checkbox"/> Exercise inhibited by condition <input type="checkbox"/> Exercising Regularly <input type="checkbox"/> Physical activity tolerance recently decreased	<p><b>What is your language preference?</b></p> <input type="checkbox"/> Communicates by sign language <input type="checkbox"/> Difficulty Understanding English <input type="checkbox"/> Native language English <input type="checkbox"/> Native language Spanish <input type="checkbox"/> Other Native language:	<p><b>What are your living arrangements?</b></p> <input type="checkbox"/> Independently Alone <input type="checkbox"/> Independently with Spouse <input type="checkbox"/> Residential Institution <input type="checkbox"/> With Caring for Child/Children <input type="checkbox"/> With Grandparent(s) <input type="checkbox"/> With Parent(s) <input type="checkbox"/> With Roomate(s)
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<p><b>What is your marital status?</b></p> <input type="checkbox"/> Currently Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Single <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed	<p><b>Are you on any specific Nutritional Plan or Diet(s):</b></p> <input type="checkbox"/> High in Fiber <input type="checkbox"/> Low in Sugar <input type="checkbox"/> Low in Cholesterol <input type="checkbox"/> Vegetarian Diet - Vegan <input type="checkbox"/> Low in Fat <input type="checkbox"/> Other: _____
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**Do you now or have you ever smoked or chewed tobacco?**     Never     Previously Used Tobacco \_\_\_\_\_ years

<input type="checkbox"/> Tobacco Use (Current) <input type="checkbox"/> Cigarettes (packs) _____ per day <input type="checkbox"/> Cigars or Pipe (pipefuls) _____ per day <input type="checkbox"/> Chewing or Snuff _____ per day	<input type="checkbox"/> Wishing to stop smoking _____ per day                _____ years _____ per day                _____ years _____ per day                _____ years
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**Allergies**

<p><b>Do you have any Drug allergies?</b>    <input type="checkbox"/> No          if yes:  <b>Are you allergic to any of the following?</b></p> <input type="checkbox"/> Aspirin <input type="checkbox"/> Penicillin <input type="checkbox"/> Dyes for X-ray tests <input type="checkbox"/> Sulfa	<p><input type="checkbox"/> No known allergies</p> <p><b>Do you have any Food / Environmental Allergies?</b>    <input type="checkbox"/> No          if yes:  <b>Are you allergic to any of the following?</b></p> <input type="checkbox"/> Dairy <input type="checkbox"/> Latex <input type="checkbox"/> Eggs <input type="checkbox"/> Shellfish
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<b>Have you had other problems with any other medications?</b>			<b>Have you had other problems with any other allergens?:</b>		
Name of Medication:	Reaction:	Date	Substance:	Reaction:	Date
		/ /			/ /
		/ /			/ /
		/ /			/ /
		/ /			/ /





Are you Experiencing Any of the Following Symptoms?

**Constitutional:**

- |                              |                             |                                 |                              |                             |   |                              |                             |   |
|------------------------------|-----------------------------|---------------------------------|------------------------------|-----------------------------|---|------------------------------|-----------------------------|---|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Fever  | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Feeling poorly | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <i>Recent:</i>                                  |
| <input type="checkbox"/>     | <input type="checkbox"/>    | <input type="checkbox"/> Chills | <input type="checkbox"/>     | <input type="checkbox"/>    | <input type="checkbox"/> Feeling tired  | <input type="checkbox"/>     | <input type="checkbox"/>    | <input type="checkbox"/> Weight Gain (____)Lbs. |
|                              |                             |                                 |                              |                             |   | <input type="checkbox"/>     | <input type="checkbox"/>    | <input type="checkbox"/> Weight Loss (____)Lbs. |

**Eyes:**

- |                          |                          |                                   |                          |                          |  |                          |                          |                                    |
|--------------------------|--------------------------|-----------------------------------|--------------------------|--------------------------|--|--------------------------|--------------------------|------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Eye Pain | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Eyesight Problems   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Dry Eyes  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Red Eyes | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Discharge from Eyes | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Eyes Itch |

**ENT:**

- |                          |                          |  |                          |                          |  |                          |                          |                                      |
|--------------------------|--------------------------|--|--------------------------|--------------------------|--|--------------------------|--------------------------|--------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Earache         | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Nosebleeds      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Sore Throat |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Loss of Hearing | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Nasal Discharge | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Hoarseness  |

**Cardiovascular:**

- |                          |                          |   |                          |                          |   |                          |                          |  |
|--------------------------|--------------------------|---|--------------------------|--------------------------|---|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Heart Rate is Slow | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Chest Pain                 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Leg Pain with walking |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Heart Rate is Fast | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Palpitations/Skipped Beats | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Leg/Foot Swelling     |

**Respiratory:**

- |                          |                          |  |                          |                          |  |                          |                          |   |
|--------------------------|--------------------------|--|--------------------------|--------------------------|--|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Cough                       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Hard breathing when flat |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Wheezing            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Short of breath w/ activity | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Short of Breath at night |

**Gastrointestinal:**

- |                          |                          |   |                          |                          |                                       |                          |                          |  |
|--------------------------|--------------------------|---|--------------------------|--------------------------|---------------------------------------|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Abdominal Pain | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Constipation | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Heartburn           |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Vomiting       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Diarrhea     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Bloody/Black stools |

**Genitourinary:**

- |                          |                          |  |                          |                          |  |                          |                          |   |
|--------------------------|--------------------------|--|--------------------------|--------------------------|--|--------------------------|--------------------------|---|
|                          |                          | <b>Females:</b>                                |                          |                          |  |                          |                          |   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Pain when urinating   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Pelvic Pain                 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Vaginal Discharge    |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Involuntary urination | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Painful menstruation        | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Abn Vaginal Bleeding |
|                          |                          | <b>Males</b>                                   |                          |                          |  |                          |                          |   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Pain when urinating   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Hesitancy                   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Testicular Pain      |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Involuntary urination | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Frequent urination at night | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Erection difficulty  |

**Musculoskeletal:**

- |                          |                          |  |                          |                          |  |                          |                          |  |
|--------------------------|--------------------------|--|--------------------------|--------------------------|--|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Muscle Aches    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Joint Pain      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Limb Pain     |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Muscle Weakness | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Joint Swelling  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Limb Swelling |
|                          |                          |  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Joint Stiffness |                          |                          |  |

**Integumentary:**

- |                          |                          |                                      |                          |                          |   |  |  |  |
|--------------------------|--------------------------|--------------------------------------|--------------------------|--------------------------|---|--|--|--|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Skin Lesion | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Itching          |  |  |  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Skin Wound  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Change in a Mole |  |  |  |

**Neurologic:**

- |                          |                          |   |                          |                          |   |                          |                          |   |
|--------------------------|--------------------------|---|--------------------------|--------------------------|---|--------------------------|--------------------------|---|
|                          |                          | <b>Females:</b>                               |                          |                          | <b>Males:</b>                           |                          |                          |   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Breast Pain          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Dry Skin       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Limb Weakness      |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Breast Lump          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Unusual Growth | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Difficulty Walking |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Confused             | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Dizziness      | <input type="checkbox"/> | <input type="checkbox"/> |   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Convulsions/Seizures | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Fainting       | <input type="checkbox"/> | <input type="checkbox"/> |   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Headache             |                          |                          |   |                          |                          |   |

**Psychiatric:**

- |                          |                          |   |                          |                          |                                     |                          |                          |  |
|--------------------------|--------------------------|---|--------------------------|--------------------------|-------------------------------------|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Suicidal           | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Anxiety    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Change in Personality |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Sleep Disturbances | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Depression | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Emotional Problems    |

**Endocrine:**

- |                          |                          |                                       |                          |                          |   |                          |                          |   |
|--------------------------|--------------------------|---------------------------------------|--------------------------|--------------------------|---|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Bulging Eyes | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Deepening of the Voice | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Feelings of Weakness |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Hot Flashes  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Increased Thirst       |                          |                          |   |

**Hematologic/Lymphatic:**

- |                          |                          |  |                          |                          |  |  |  |  |
|--------------------------|--------------------------|--|--------------------------|--------------------------|--|--|--|--|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Easy Bleeding | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Swollen Glands        |  |  |  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Easy Bruising | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Swollen Glands - Neck |  |  |  |

**Other Symptoms:**

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