

PATIENT NAME: _____ Date: _____

<p>Please indicate if you are having any current problems, signs or symptoms in any of the following areas:</p> <p>✓</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; vertical-align: top; border: none;"> <input type="checkbox"/> General Wellness <input type="checkbox"/> Eyes <input type="checkbox"/> Skin <input type="checkbox"/> Ears, Nose, Throat <input type="checkbox"/> Stomach/Digestion <input type="checkbox"/> Lungs/Breathing <input type="checkbox"/> Heart/Circulation <input type="checkbox"/> Dizziness <input type="checkbox"/> Trouble Sleeping <input type="checkbox"/> Chest Pains <input type="checkbox"/> Muscles/Joints/Bones </td> <td style="width: 50%; vertical-align: top; border: none;"> <p>✓</p> <input type="checkbox"/> Neurological <input type="checkbox"/> Allergies <input type="checkbox"/> Reproductive/Urinary <input type="checkbox"/> Thyroid/Endocrine <input type="checkbox"/> Psychiatric <input type="checkbox"/> Blood/Lymph <input type="checkbox"/> Other <input type="checkbox"/> Giddiness <input type="checkbox"/> Memory <input type="checkbox"/> Fatigue <input type="checkbox"/> Other </td> </tr> </table>	<input type="checkbox"/> General Wellness <input type="checkbox"/> Eyes <input type="checkbox"/> Skin <input type="checkbox"/> Ears, Nose, Throat <input type="checkbox"/> Stomach/Digestion <input type="checkbox"/> Lungs/Breathing <input type="checkbox"/> Heart/Circulation <input type="checkbox"/> Dizziness <input type="checkbox"/> Trouble Sleeping <input type="checkbox"/> Chest Pains <input type="checkbox"/> Muscles/Joints/Bones	<p>✓</p> <input type="checkbox"/> Neurological <input type="checkbox"/> Allergies <input type="checkbox"/> Reproductive/Urinary <input type="checkbox"/> Thyroid/Endocrine <input type="checkbox"/> Psychiatric <input type="checkbox"/> Blood/Lymph <input type="checkbox"/> Other <input type="checkbox"/> Giddiness <input type="checkbox"/> Memory <input type="checkbox"/> Fatigue <input type="checkbox"/> Other	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 15%; text-align: center; vertical-align: top;">Physician</td> <td style="width: 85%; text-align: center; vertical-align: top;">Comments - Review of systems</td> </tr> <tr> <td colspan="2" style="height: 150px; vertical-align: bottom; padding: 5px;"> <input type="checkbox"/> All other systems negative ROS: 1 prob pertinent, 2-9 extended, 10+ complete </td> </tr> </table>	Physician	Comments - Review of systems	<input type="checkbox"/> All other systems negative ROS: 1 prob pertinent, 2-9 extended, 10+ complete	
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<p>Have you seen any other doctors since your last visit here? YES NO ___/___/___</p>	<p>WHEN? Reason you saw the other doctor?</p>						
<p>Reason for Today's Visit:</p>	<p>Please list any allergies you have:</p>						
<p>Current Medications</p>	<p>Since your last visit, please note any changes to: Marital Status, Job, Smoking or Drinking</p>						