TO HELP US SERVE YOU BETTER
PLEASE MARK "*YES*" OR "*NO*" TO THE FOLLOWING QUESTIONS
BEFORE YOU SEE THE DOCTOR

GENERAL — YES NO

1. Fever
2. Chills
3. Weight loss
4. Night sweats
5. Other___________________

EARS — YES NO

1. Hearing loss - gradual
2. Hearing loss - sudden
3. Pain
4. Ringing
5. Dizziness or vertigo
6. Frequent infections
7. Other___________________

NOSE — YES NO

1. Nose bleeds
2. Injury
3. Congestion
4. Runny nose
5. Mouth breather
6. Other___________________

THROAT — YES NO

1. Frequent sore throats
2. Difficulty swallowing
3. Hoarseness
4. Foreign body
5. Thyroid problems
6. Swollen tonsils
7. Sleep Apnea
8. Trouble breathing at night
9. Snoring
10. Daytime sleepiness

EYES — YES NO

1. Cataracts
2. Glaucoma
3. Distorted vision

HEART — YES NO

1. High blood pressure
2. Chest pain
3. Irregular heart beat
4. Previous heart attack
5. Other___________________

LUNGS — YES NO

1. Bronchitis/chronic cough
2. Asthma/wheezing
3. Congestion
4. Other___________________

GASTROINTESTINAL — YES NO

1. Indigestion / heartburn
2. Ulcers
3. Diarrhea
4. Diverticulitis
5. Gall bladder trouble
6. Nausea & vomiting
7. Other___________________

URINARY TRACT — YES NO

1. Kidney problems
2. Painful urination
3. Bloody urination
4. Prostate problems (men)
5. Other___________________

MUSCULOSKELETAL — YES NO

1. Back pain
2. Weakness of limbs
3. Arthritis
4. Other___________________

NEUROLOGICAL — YES NO

1. Numbness
2. Migraine headaches
3. Seizures
4. Convulsions
5. Stroke
6. Other___________________

ENDOCRINE — YES NO

1. Thyroid disorders
2. Diabetes
3. Menopause (women)
4. Hormonal replacement
5. Pregnant (women)
6. Other___________________

BLOOD DISORDERS — YES NO

1. Low blood counts
2. Free bleeding
3. Blood clots
4. Blood disorders
5. Hepatitis
6. Other___________________

ALLERGY/IMMUNE — YES NO

1. Seasonal allergies
2. Itchy eyes
3. Runny nose
4. Allergy testing in past
5. HIV or AIDS
6. Other___________________