

CONSTITUTIONAL

- Fever Yes No
- Body Aches Yes No
- Ill Contacts Yes No
- Weight Loss Yes No
- Loss of Appetite Yes No
- Sleep Problems Yes No

ALLERGY

- Angioedema Yes No
- Itchy Eyes Yes No
- Post-nasal Drip Yes No
- Sneezing Yes No

DERMATOLOGY

- Rash Yes No
- Dry or Sensitive Skin Yes No
- Mole Yes No
- Skin Cancer Yes No

ENT

- Hearing Loss Yes No
- Sore Throat Yes No
- Ear Pain Yes No
- Change in voice Yes No
- Runny Nose Yes No
- Ringing in Ears Yes No
- Nasal Congestion Yes No
- Snoring Yes No

OPHTHALMOLOGY

- Eye Redness/Irritation Yes No
- Change in Vision Yes No
- Wear Glasses/Corrective Lenses Yes No

CARDIOLOGY

- Chest Pain Yes No
- Irregular Heart Beat Yes No
- Palpitations Yes No
- Lightheaded Yes No
- Leg Edema Yes No
- PND/Orthopnea Yes No
- Syncope Yes No

RESPIRATORY

- Wheezing Yes No
- Shortness of Breath/Difficulty Breathing While Lying Down Yes No
- Cough Yes No
- Hemoptysis Yes No

ENDOCRINOLOGY

- Cold Intolerance Yes No
- Heat Intolerance Yes No
- Polyuria Yes No
- Polyphagia Yes No
- Weight Gain Yes No

ENDOCRINOLOGY

- Hair Loss Yes No
- Hyperglycemia Yes No
- Hypoglycemia Yes No
- Increase in Appetite Yes No

GASTROENTEROLOGY

- Abdominal Pain Yes No
- Heartburn/Acid Reflux Yes No
- Diarrhea Yes No
- Constipation Yes No
- Hemorrhoids Yes No
- Blood in Stool Yes No
- Nausea/Vomiting Yes No
- Dysphagia Yes No

HEMATOLOGY/LYMPH

- Swollen Glands Yes No
- Easy Bruising Yes No

MALE REPRODUCTIVE

- Penile Discharge Yes No
- Diminished Sexual Drive Yes No
- Testicular Pain/Lump Yes No
- STDs Yes No

FEMALE REPRODUCTIVE

- Heavy periods Yes No
- Irregular Menses Yes No

FEMALE REPRODUCTIVE

- | | | |
|----------------------------|---------------------------|--------------------------|
| Abnormal Vaginal Discharge | <input type="radio"/> Yes | <input type="radio"/> No |
| Hot Flashes | <input type="radio"/> Yes | <input type="radio"/> No |
| Pelvic Pain | <input type="radio"/> Yes | <input type="radio"/> No |
| STDs | <input type="radio"/> Yes | <input type="radio"/> No |
| Diminished Sexual Drive | <input type="radio"/> Yes | <input type="radio"/> No |

MUSCULOSKELETAL

- | | | |
|-----------------|---------------------------|--------------------------|
| Back Pain | <input type="radio"/> Yes | <input type="radio"/> No |
| Joint Pain | <input type="radio"/> Yes | <input type="radio"/> No |
| Joint Swelling | <input type="radio"/> Yes | <input type="radio"/> No |
| Joint Stiffness | <input type="radio"/> Yes | <input type="radio"/> No |

UROLOGY

- | | | |
|-------------------------|---------------------------|--------------------------|
| Burning while urinating | <input type="radio"/> Yes | <input type="radio"/> No |
| Urinary Frequency | <input type="radio"/> Yes | <input type="radio"/> No |
| Urinary Incontinence | <input type="radio"/> Yes | <input type="radio"/> No |
| Difficulty urinating | <input type="radio"/> Yes | <input type="radio"/> No |
| Blood in Urine | <input type="radio"/> Yes | <input type="radio"/> No |
| Nocturia | <input type="radio"/> Yes | <input type="radio"/> No |

NEUROLOGY

- | | | |
|-------------------|---------------------------|--------------------------|
| Seizures | <input type="radio"/> Yes | <input type="radio"/> No |
| Weakness | <input type="radio"/> Yes | <input type="radio"/> No |
| Dizziness | <input type="radio"/> Yes | <input type="radio"/> No |
| Memory Loss | <input type="radio"/> Yes | <input type="radio"/> No |
| Headache | <input type="radio"/> Yes | <input type="radio"/> No |
| Tingling/Numbness | <input type="radio"/> Yes | <input type="radio"/> No |

PSYCHOLOGY

- | | | |
|----------------------------|---------------------------|--------------------------|
| Stressors | <input type="radio"/> Yes | <input type="radio"/> No |
| Depression | <input type="radio"/> Yes | <input type="radio"/> No |
| Anxiety | <input type="radio"/> Yes | <input type="radio"/> No |
| Mood Swings | <input type="radio"/> Yes | <input type="radio"/> No |
| Hallucinations | <input type="radio"/> Yes | <input type="radio"/> No |
| Suicidal Ideation/Thoughts | <input type="radio"/> Yes | <input type="radio"/> No |
| Mental or Physical Abuse | <input type="radio"/> Yes | <input type="radio"/> No |