

MEDICAL HISTORY

HAVE YOU, OR HAVE YOU EVER HAD: (CHECK ALL THAT APPLY)

- | | | |
|--|---|---|
| <input type="checkbox"/> fatigue | <input type="checkbox"/> painful urination | <input type="checkbox"/> seasonal allergies |
| <input type="checkbox"/> weakness | <input type="checkbox"/> frequent urination | <input type="checkbox"/> rashes |
| <input type="checkbox"/> exercise intolerance | <input type="checkbox"/> blood in urine | <input type="checkbox"/> hives |
| <input type="checkbox"/> unexpected weight loss | <input type="checkbox"/> pelvic pain | <input type="checkbox"/> itching |
| <input type="checkbox"/> unexpected weight gain | <input type="checkbox"/> testicular pain | <input type="checkbox"/> sneezing |
| <input type="checkbox"/> chills | <input type="checkbox"/> kidney disease | <input type="checkbox"/> nasal drainage |
| <input type="checkbox"/> night sweats | <input type="checkbox"/> renal failure | |
| <input type="checkbox"/> inability to sleep | | |
| | <input type="checkbox"/> painful joints | <input type="checkbox"/> blood transfusion |
| <input type="checkbox"/> blurred vision | <input type="checkbox"/> swollen joints | <input type="checkbox"/> blood clot |
| <input type="checkbox"/> double vision | <input type="checkbox"/> arthritis | <input type="checkbox"/> bone infection |
| <input type="checkbox"/> glaucoma | <input type="checkbox"/> muscle pain | <input type="checkbox"/> adverse reaction to medication |
| <input type="checkbox"/> cataracts | <input type="checkbox"/> muscle weakness | <input type="checkbox"/> problem during anesthesia |
| <input type="checkbox"/> spots | <input type="checkbox"/> muscle cramps | <input type="checkbox"/> infection following surgery |
| <input type="checkbox"/> floaters | <input type="checkbox"/> deformity | |
| | | <input type="checkbox"/> broken bone |
| <input type="checkbox"/> loss of hearing | <input type="checkbox"/> skin lesions | <input type="checkbox"/> cancer |
| <input type="checkbox"/> ringing in ears | <input type="checkbox"/> skin disease | <input type="checkbox"/> heart attack |
| <input type="checkbox"/> vertigo | <input type="checkbox"/> sores | <input type="checkbox"/> stroke |
| <input type="checkbox"/> frequent nosebleeds | <input type="checkbox"/> moles that change in size or color | <input type="checkbox"/> hepatitis |
| <input type="checkbox"/> sinusitis | <input type="checkbox"/> breaking out | <input type="checkbox"/> HIV |
| <input type="checkbox"/> hoarseness | <input type="checkbox"/> lumps / nodules | |
| <input type="checkbox"/> difficulty swallowing | | <u>OTHER:</u> _____ |
| <input type="checkbox"/> bleeding gums | <input type="checkbox"/> frequent headaches | _____ |
| | <input type="checkbox"/> migraine headaches | _____ |
| <input type="checkbox"/> chest pain | <input type="checkbox"/> syncope | _____ |
| <input type="checkbox"/> rapid heartbeat | <input type="checkbox"/> blacking out | _____ |
| <input type="checkbox"/> palpitations | <input type="checkbox"/> memory loss | _____ |
| <input type="checkbox"/> shortness of breath with exertion | <input type="checkbox"/> disorientation | _____ |
| <input type="checkbox"/> heart attack | <input type="checkbox"/> head injury | _____ |
| <input type="checkbox"/> heart disease | <input type="checkbox"/> loss of vision | _____ |
| <input type="checkbox"/> high blood pressure | <input type="checkbox"/> stroke | _____ |
| <input type="checkbox"/> congestive heart failure | <input type="checkbox"/> seizures | _____ |
| | <input type="checkbox"/> numbness | _____ |
| <input type="checkbox"/> difficulty breathing | <input type="checkbox"/> tingling | _____ |
| <input type="checkbox"/> asthma | | |
| <input type="checkbox"/> emphysema | <input type="checkbox"/> anxiety | |
| <input type="checkbox"/> COPD | <input type="checkbox"/> depression | |
| <input type="checkbox"/> bloody sputum | <input type="checkbox"/> bipolar disorder | |
| | <input type="checkbox"/> panic attacks | |
| <input type="checkbox"/> indigestion | | |
| <input type="checkbox"/> nausea | <input type="checkbox"/> diabetes | |
| <input type="checkbox"/> vomiting | <input type="checkbox"/> thyroid disorder | |
| <input type="checkbox"/> changes in bowel habits | <input type="checkbox"/> excessive thirst | |
| <input type="checkbox"/> diarrhea | <input type="checkbox"/> hair loss | |
| <input type="checkbox"/> bloating | <input type="checkbox"/> skin changes | |
| <input type="checkbox"/> abdominal pain | <input type="checkbox"/> nail changes | |
| <input type="checkbox"/> cramping | | |
| <input type="checkbox"/> inability to eat certain foods | <input type="checkbox"/> bruise easily | |
| <input type="checkbox"/> ulcers | <input type="checkbox"/> bleeding disorder | |
| <input type="checkbox"/> colitis | <input type="checkbox"/> blood clots | |
| <input type="checkbox"/> reflux | <input type="checkbox"/> lymph node enlargement | |
| <input type="checkbox"/> heartburn | | |
| <input type="checkbox"/> blood in stool | | |