Name:_____ **DOB:**_____ **Date Of Service:**_____

Have you had any of the following problems in the past year? Place an X to the left if YES.

___ Insomnia
___ Abnormal Weight loss/gain
___ Hot flashes/night sweats
___ Undue fatigue
___ Change in a mole or skin lesion
___ Rash
___ Headache
___ Lightheadedness/vertigo/dizziness
___ Change in hearing
___ Fullness/ringing in ears
___ Change in vision
___ Itchy/watery eyes
___ Sinus congestion (other than a cold)
___ Frequent runny nose (other than a cold)
___ Post nasal drip
___ Oral lesions or sores
___ Tooth pain
___ Gum disease
___ Hoarseness of voice (other than a cold)
___ Breast lump
___ Nipple discharge
___ Chest tightness/pressure/pain
___ Palpations
___ Swelling in feet, ankles, legs
___ Calf pain with exertion
___ Shortness of breath with exertion/lying flat in bed
___ Frequent coughing (other than a cold)
___ Wheezing
___ Excessive thirst/hunger
___ Hot/cold intolerance
___ Pain or difficulty with swallowing
___ Frequent indigestion/heartburn
___ Nausea/vomiting
___ Constipation/diarrhea
___ Blood in stool or other change in appearance
___ Burning or discomfort with urination
___ Urinary frequency or urgency
___ Loss of control of urine
___ Blood in urine
___ Abnormal vaginal discharge
___ Joint pain, swelling, stiffness, redness
___ Unusual muscle ache or pain
___ Weakness, numbness, or tingling or extremity
___ Irritability
___ Lack/diminished interest in doing things that used to give you pleasure
___ Anxiety/depression
___ Alcohol use of more than 1-2 drinks/day
___ Other symptoms/concerns/complaints (please specify)