

WITHIN THE PAST FEW MONTHS HAVE YOU HAD OR DO YOU SUFFER FROM ANY OF THE FOLLOWING? PLEASE CHECK IF THE ANSWER IS "YES".

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| <input type="checkbox"/> HEADACHE | <input type="checkbox"/> SEIZURES |
| <input type="checkbox"/> DIZZINESS | <input type="checkbox"/> FAINTING |
| <input type="checkbox"/> HEAD INJURY | <input type="checkbox"/> LOSS OF CONSCIOUSNESS |
| <input type="checkbox"/> EMOTIONAL PROBLEMS | <input type="checkbox"/> DEPRESSION |
| <input type="checkbox"/> NOSE BLEEDS | <input type="checkbox"/> CHRONIC NASAL STUFFINESS |
| <input type="checkbox"/> SINUS INFECTIONS | <input type="checkbox"/> VISUAL PROBLEMS |
| <input type="checkbox"/> DOUBLE VISION | <input type="checkbox"/> BLURRED VISION |
| <input type="checkbox"/> COLOR BLINDNESS | <input type="checkbox"/> GLAUCOMA |
| <input type="checkbox"/> DENTAL PROBLEMS | <input type="checkbox"/> FREQUENT SORE THROATS |
| <input type="checkbox"/> NECK INJURY | <input type="checkbox"/> DIFFICULT OR PAINFUL SWALLOWING |
| <input type="checkbox"/> NECK PAIN | <input type="checkbox"/> THYROID PROBLEMS |
| <input type="checkbox"/> CHEST PAIN | <input type="checkbox"/> IRREGULAR HEART BEAT |
| <input type="checkbox"/> RHEUMATIC FEVER | <input type="checkbox"/> HEART MURMUR |
| <input type="checkbox"/> FEET OR ANKLE SWELLING | <input type="checkbox"/> TROUBLE WITH ARTERIES OR VEINS |
| <input type="checkbox"/> LEG CRAMPS WITH WALKING | <input type="checkbox"/> CHRONIC COUGH |
| <input type="checkbox"/> CHRONIC BRONCHITIS | <input type="checkbox"/> COLLAPSED LUNG |
| <input type="checkbox"/> NUMBNESS IN ARMS OR LEGS | <input type="checkbox"/> PAIN IN ARMS OR LEGS |
| <input type="checkbox"/> FREQUENT BELCHING | <input type="checkbox"/> INDIGESTION |
| <input type="checkbox"/> BURNING ABDOMINAL PAIN | <input type="checkbox"/> ULCER / GASTRITIS |
| <input type="checkbox"/> VOMIT BLOOD | <input type="checkbox"/> BLOOD IN STOOL (BOWEL MOVEMENTS) |
| <input type="checkbox"/> FOODS YOU CANT TOLERATE | <input type="checkbox"/> GALL BLADDER PROBLEMS |
| <input type="checkbox"/> LIVER DISEASE | <input type="checkbox"/> HEPATITIS |
| <input type="checkbox"/> UNEXPLAINED BELLY PAIN | <input type="checkbox"/> DIARRHEA OR CONSTIPATION |
| <input type="checkbox"/> BLACK STOOLS | <input type="checkbox"/> HEMORRHOIDS |
| <input type="checkbox"/> KIDNEY OR BLADDER INFECTIONS | <input type="checkbox"/> KIDNEY OR BLADDER STONES |
| <input type="checkbox"/> PROSTATE INFECTIONS | <input type="checkbox"/> PROSTATE ENLARGEMENT |
| <input type="checkbox"/> TROUBLE STARTING URINE | <input type="checkbox"/> TROUBLE HOLDING URINE |
| <input type="checkbox"/> FREQUENT URINATION | <input type="checkbox"/> PROBLEMS WITH SEXUAL FUNCTION |
| <input type="checkbox"/> JOINT PROBLEMS | <input type="checkbox"/> HAVE YOU EVER HAD A SEXUALLY TRANSMITTED DISEASE? (V.D.) |
| <input type="checkbox"/> ARTHRITIS | <input type="checkbox"/> PROBLEMS WITH PANCREAS |
| <input type="checkbox"/> PROBLEMS WITH MUSCLES | <input type="checkbox"/> TOENAIL OR FINGERNAIL PROBLEMS |
| <input type="checkbox"/> HEAD OR SCALP PROBLEMS | <input type="checkbox"/> PHLEBITIS |
| <input type="checkbox"/> PROBLEMS WITH YOUR FEET | <input type="checkbox"/> ANEMIA |
| <input type="checkbox"/> SCARLET FEVER | <input type="checkbox"/> NEUROLOGIC DISORDER |
| <input type="checkbox"/> SICKLE CELL DISEASE/TRAIT | <input type="checkbox"/> BLOOD TRANSFUSION |
| <input type="checkbox"/> LOW BLOOD SUGAR | <input type="checkbox"/> RECENT CHANGE IN WART OR MOLE |
| <input type="checkbox"/> SHORT WINDED WITH WALKING OR CLIMBING STAIRS | <input type="checkbox"/> HOW MANY PILLOWS DO YOU SLEEP ON AT NIGHT? _____ |
| <input type="checkbox"/> DO YOU USE ANY RECREATIONAL DRUGS? (STREET DRUGS) | <input type="checkbox"/> ANY DRUG ALLERGIES? |

COMMENTS:

NAME _____

DATE _____