

**Please check All Conditions You Currently Have or Have Had**

<p><b>General Questions</b></p> <p><input type="checkbox"/> Weight loss</p> <p><input type="checkbox"/> Weight gain</p> <p><input type="checkbox"/> Change in sleep patterns</p> <p><input type="checkbox"/> Change in activity capacity</p>	<p><b>Provider Signature</b></p> <p>Conditions.wpd</p> <p><b>Cardiovascular</b></p> <p><input type="checkbox"/> Angina      <input type="checkbox"/> Chest pain</p> <p><input type="checkbox"/> Leg cramps   <input type="checkbox"/> Murmurs</p> <p><input type="checkbox"/> Ankle swelling</p> <p><input type="checkbox"/> Awakening at night short of breath &amp; getting out of bed</p>	<p><input type="checkbox"/> Moles - change/new</p>	<p><input type="checkbox"/> Premature ejaculation</p> <p><input type="checkbox"/> Problems maintaining or keeping an erection</p> <p><input type="checkbox"/> Prostate disease</p> <p><input type="checkbox"/> Sores on penis or warts</p> <p><input type="checkbox"/> Testicular pain</p> <p><input type="checkbox"/> Testicular swelling</p>
<p><b>Neurological and Psychiatric</b></p> <p><input type="checkbox"/> Anxiety</p> <p><input type="checkbox"/> Headaches</p> <p><input type="checkbox"/> Depression</p> <p><input type="checkbox"/> Meningitis</p> <p><input type="checkbox"/> Paralysis</p> <p><input type="checkbox"/> Seizure</p> <p><input type="checkbox"/> Stroke</p> <p><input type="checkbox"/> Tingling</p> <p><input type="checkbox"/> Tremors</p> <p><input type="checkbox"/> Memory loss</p> <p><input type="checkbox"/> Fainting spells, dizziness</p> <p><input type="checkbox"/> Head injuries</p> <p><input type="checkbox"/> Blackouts or near blackouts</p> <p><input type="checkbox"/> Change in sensation anywhere on your body</p> <p><input type="checkbox"/> Localized weakness or numbness</p>	<p><input type="checkbox"/> Cardiac catheterization</p> <p><input type="checkbox"/> Cold hands or feet</p> <p><input type="checkbox"/> Congenital heart defects</p> <p><input type="checkbox"/> Dizziness when standing up quickly</p> <p><input type="checkbox"/> Heart attacks</p> <p><input type="checkbox"/> Heart failure</p> <p><input type="checkbox"/> High or low blood pressure</p> <p><input type="checkbox"/> Irregular heart rate</p> <p><input type="checkbox"/> Purple fingers or lips</p> <p><input type="checkbox"/> Leg pain that resolves with rest</p> <p><input type="checkbox"/> Heart Palpitations</p> <p><input type="checkbox"/> Varicose veins</p>	<p><b>Kidneys &amp; Urinary Tract</b></p> <p><input type="checkbox"/> Blood in urine</p> <p><input type="checkbox"/> Brown urine</p> <p><input type="checkbox"/> Dribbling after Urination</p> <p><input type="checkbox"/> Painful urination</p> <p><input type="checkbox"/> Excessive thirst</p> <p><input type="checkbox"/> Involuntary Urination / Incontinence</p> <p><input type="checkbox"/> Urinating frequently (day)</p> <p><input type="checkbox"/> Urinating frequently (night)</p> <p><input type="checkbox"/> Urine hesitancy</p> <p><input type="checkbox"/> Weak flow</p> <p><input type="checkbox"/> Frequent bladder infections</p> <p><input type="checkbox"/> Kidney disease</p> <p><input type="checkbox"/> Kidney stone</p>	<p><b>Musculoskeletal</b></p> <p><input type="checkbox"/> Anemia      <input type="checkbox"/> Arthritis</p> <p><input type="checkbox"/> Back pain   <input type="checkbox"/> Bursitis</p> <p><input type="checkbox"/> Gout         <input type="checkbox"/> Joint aches</p> <p><input type="checkbox"/> Neck pain   <input type="checkbox"/> Tendinitis</p> <p><input type="checkbox"/> Abnormal Blood Counts</p> <p><input type="checkbox"/> Bone Marrow Biopsy</p> <p><input type="checkbox"/> Easy Bleeding</p> <p><input type="checkbox"/> Easy bruising</p> <p><input type="checkbox"/> Joint swelling</p> <p><input type="checkbox"/> Morning stiffness</p> <p><input type="checkbox"/> Muscle aches</p>
<p><b>Ears, Eyes, Nose &amp; Throat</b></p> <p><input type="checkbox"/> Hay fever</p> <p><input type="checkbox"/> Glaucoma</p> <p><input type="checkbox"/> Polyps</p> <p><input type="checkbox"/> Allergy</p> <p><input type="checkbox"/> Cataracts</p> <p><input type="checkbox"/> Goiter</p> <p><input type="checkbox"/> Hoarseness</p> <p><input type="checkbox"/> Double vision</p> <p><input type="checkbox"/> Gum problems</p> <p><input type="checkbox"/> Eye problems</p> <p><input type="checkbox"/> Ear infections</p> <p><input type="checkbox"/> Glasses/Contacts</p> <p><input type="checkbox"/> Hearing Loss</p> <p><input type="checkbox"/> Ear discharge/Pain</p> <p><input type="checkbox"/> Frequent nosebleeds</p> <p><input type="checkbox"/> Ringing in your ears</p> <p><input type="checkbox"/> Sinus infections</p> <p><input type="checkbox"/> Swollen glands</p>	<p><b>Respiratory</b></p> <p><input type="checkbox"/> Pleurisy      <input type="checkbox"/> Wheezing</p> <p><input type="checkbox"/> Asthma</p> <p><input type="checkbox"/> Breathlessness when laying flat</p> <p><input type="checkbox"/> Prolonged cough</p> <p><input type="checkbox"/> Coughing up blood</p> <p><input type="checkbox"/> Emphysema</p> <p><input type="checkbox"/> Shortness of breath</p> <p><input type="checkbox"/> Tuberculosis</p> <p><input type="checkbox"/> Pneumonia</p> <p><input type="checkbox"/> Frequent infections (bronchitis)</p> <p><b>Skin</b></p> <p><input type="checkbox"/> Abscess      <input type="checkbox"/> Dandruff</p> <p><input type="checkbox"/> Acne         <input type="checkbox"/> Oily Skin</p> <p><input type="checkbox"/> Boils        <input type="checkbox"/> Rashes</p> <p><input type="checkbox"/> Hives        <input type="checkbox"/> Dry skin</p> <p><input type="checkbox"/> Lumps       <input type="checkbox"/> Psoriasis</p>	<p><b>Endocrine</b></p> <p><input type="checkbox"/> Diabetes</p> <p><input type="checkbox"/> Sickle Cell</p> <p><input type="checkbox"/> Abnormal body hair</p> <p><input type="checkbox"/> Changes in skin texture</p> <p><input type="checkbox"/> Cold intolerance</p> <p><input type="checkbox"/> Heat intolerance</p> <p><input type="checkbox"/> History of "borderline" diabetes</p> <p><input type="checkbox"/> Increased loss of hair</p> <p><input type="checkbox"/> Rheumatism</p> <p><input type="checkbox"/> Thyroid disease</p> <p><b>Male &amp; Female</b></p> <p><input type="checkbox"/> Painful sexual intercourse</p> <p><input type="checkbox"/> Loss of sexual interest</p> <p><input type="checkbox"/> Unprotected sex</p> <p><input type="checkbox"/> Groin itching</p> <p><input type="checkbox"/> Sexually transmitted diseases</p> <p><b>Males Only</b></p> <p><input type="checkbox"/> Hernia</p> <p><input type="checkbox"/> Sterility</p>	<p><b>Gastrointestinal</b></p> <p><input type="checkbox"/> Diarrhea      <input type="checkbox"/> Gallstones</p> <p><input type="checkbox"/> Reflux        <input type="checkbox"/> Vomiting</p> <p><input type="checkbox"/> Ulcers        <input type="checkbox"/> Heartburn</p> <p><input type="checkbox"/> Hepatitis     <input type="checkbox"/> Indigestion</p> <p><input type="checkbox"/> Abdominal pain</p> <p><input type="checkbox"/> Anal fissures</p> <p><input type="checkbox"/> Black tarry stools</p> <p><input type="checkbox"/> Vomiting blood</p> <p><input type="checkbox"/> Constipation</p> <p><input type="checkbox"/> Nausea</p> <p><input type="checkbox"/> Problems swallowing</p> <p><input type="checkbox"/> Hiatal Hernia</p> <p><input type="checkbox"/> Intestinal obstruction</p> <p><input type="checkbox"/> Liver disease</p> <p><input type="checkbox"/> Hemorrhoids</p> <p><input type="checkbox"/> Red blood after bowel movements</p>
<p><i>Provider Notes</i></p>	<p><input type="checkbox"/> Jaundice</p> <p><input type="checkbox"/> Athlete's foot</p> <p><input type="checkbox"/> Excessive body odor</p> <p><input type="checkbox"/> Excessive sweating</p> <p><input type="checkbox"/> fungal infections</p> <p><input type="checkbox"/> Nail problems</p> <p><input type="checkbox"/> Moles - irregular</p>	<p><input type="checkbox"/> Hernia</p> <p><input type="checkbox"/> Sterility</p> <p><input type="checkbox"/> Bloody ejaculation</p> <p><input type="checkbox"/> Inability to complete intercourse</p> <p><input type="checkbox"/> Lump on testicle</p> <p><input type="checkbox"/> Penile discharge</p>	<p><b>Females Only</b></p> <p><input type="checkbox"/> D &amp; C</p> <p><input type="checkbox"/> Hot flashes</p> <p><input type="checkbox"/> Hernia</p> <p><input type="checkbox"/> Fibroids</p>

- 0 Abnormal bleeding between cycles
- 0 Abnormal pap smear
- 0 Bleeding after intercourse
- 0 Complications w/pregnancy
- 0 PMS
- 0 Endometriosis
- 0 Heavy bleeding during cycles
- 0 Discharge from breast
- 0 Ovarian - cysts
- 0 Pelvic inflammatory disease
- 0 Postmenopausal symptoms
- 0 Vaginal discharge
- 0 Vaginal Dryness
- 0 Vaginal warts

**Date**