

**patient demographics**

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| **Patient information** |
| **Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Social Security #**: \_\_\_\_\_\_\_\_-\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_  **Date of Birth**: \_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_ **Sex**: M F **Phone Number**: \_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_  **Mailing Address**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Address City State Zip Code  **Physical Address**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Address City State Zip Code  **Email Address**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Employer**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Employed**: Full Time Part Time Retired Disabled |

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| **RESPONSIBLE PARTY INFORMATION** |
| **Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Phone Number**: \_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_    **Mailing Address**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Address City State Zip Code  **Relationship to Patient**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **EMERGENCY CONTACT INFORMATION** |
| **Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Phone Number**: \_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_  **Relationship to Patient**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **SIGNATURE** |
| **Signature of Person Completing Form**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Relationship to Patient**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date**: \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_ |

**Insurance Information**

Primary Insurance:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Secondary Insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Group #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Holder Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SSN: \_\_\_\_\_\_\_-\_\_\_\_\_\_-\_\_\_\_\_\_\_\_

Patient Relationship to Policy Holder: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| hEALTH HISTORY QUESTIONNAIRE | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| All questions contained in this questionnaire are strictly confidential  and will become part of your medical record. | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Name (Last, First, M.I.): | | | |  | | | | | | | | M  F | | | | DOB: | |  | | | | | | | | | | |
| Marital status: | | | **Single  Partnered  Married  Separated  Divorced  Widowed** | | | | | | | | | | | | | | | | | | | | | | | | | |
| Date of last physical exam: | | | | | |  | | | | Previous or referring doctor: | | | | | | | | | |  | | | | | | | | |
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| PERSONAL HEALTH HISTORY | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Childhood illness: | | | | ¨ Measles ¨ Mumps ¨ Rubella ¨ Chickenpox ¨ Rheumatic Fever ¨ Polio | | | | | | | | | | | | | | | | | | | | | | | | |
| Immunizations and dates: | | | | | Tetanus | |  | | | Pneumonia | | | | | | | Influenza | | | | | | | | | | | |
|  | | | | | Hepatitis | |  | | | Chickenpox | | | | | | | MMR Measles, Mumps, Rubella | | | | | | | | | | | |
|  | | | | | Covid- 19 | |  | | |  | | | | | | | | |  | | | | | | | | | |
| List any medical problems that other doctors have diagnosed | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Surgeries | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Year | Reason | | | | | | | | | | | | | | Hospital | | | | | | | | | | | | | |
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| Other hospitalizations | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Year | Reason | | | | | | | | | | | | | | Hospital | | | | | | | | | | | | | |
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| Have you ever had a blood transfusion? | | | | | | | | | | | | | | | | | | | | | | |  | | Yes | |  | No |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Name the Drug | | | | | | | | | Strength | | | | | Frequency Taken | | | | | | | | | | | | | | | |
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| Allergies to medications | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Name the Drug | | | | | | | | | Reaction You Had | | | | | | | | | | | | | | | | | | | | |
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| HEALTH HABITS AND PERSONAL SAFETY | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| All questions contained in this questionnaire are optional and will be kept strictly confidential. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Exercise | | Sedentary (No exercise) | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | Occasional exercise (i.e., climb stairs, walk 3 blocks, golf) | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | Moderate exercise (i.e., work or recreation, less than 4x/week for 30 min.) | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | Heavy exercise (i.e., work or recreation 4x/week for 30 minutes) | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Diet | | Are you dieting? | | | | | | | | | | | | | | | | | | | |  | | Yes | |  | | No | |
|  | | If yes, are you on a physician prescribed medical diet? | | | | | | | | | | | | | | | | | | | |  | | Yes | |  | | No | |
|  | | # of meals you eat in an average day? | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | Rank salt intake | | | | | | Hi | | | Med | | Low | | | | | | | | | | | | | | | | |
|  | | Rank fat intake | | | | | | Hi | | | Med | | Low | | | | | | | | | | | | | | | | |
| Caffeine | | ¨ None | | | | | | Coffee | | | Tea | | Cola | | | | | | | | | | | | | | | | |
|  | | # of cups/cans per day? | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Alcohol | | Do you drink alcohol? | | | | | | | | | | | | | | | | | | | |  | | Yes | |  | | No | |
|  | | If yes, what kind? | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | How many drinks per week? | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | Are you concerned about the amount you drink? | | | | | | | | | | | | | | | | | | | |  | | Yes | |  | | No | |
|  | | Have you considered stopping? | | | | | | | | | | | | | | | | | | | |  | | Yes | |  | | No | |
|  | | Have you ever experienced blackouts? | | | | | | | | | | | | | | | | | | | |  | | Yes | |  | | No | |
|  | | Are you prone to “binge” drinking? | | | | | | | | | | | | | | | | | | | |  | | Yes | |  | | No | |
|  | |  | | | | | | | | | | | | | | | | | | | |  | |  | |  | |  | |
| Tobacco | | Do you use tobacco? | | | | | | | | | | | | | | | | | | | |  | | Yes | |  | | No | |
|  | | Cigarettes – pks./day | | | | | | | | | Chew - #/day | | Pipe - #/day | | | | | | | | Cigars - #/day | | | | | | | | |
|  | | # of years | | | | | | Or year quit | | | | | | | | | | | | | | | | | | | | | |
| Drugs | | Do you currently use recreational or street drugs? | | | | | | | | | | | | | | | | | | | |  | | Yes | |  | | No | |
|  | | Have you ever given yourself street drugs with a needle? | | | | | | | | | | | | | | | | | | | |  | | Yes | |  | | No | |
| Sex | | Are you sexually active? | | | | | | | | | | | | | | | | | | | |  | | Yes | |  | | No | |
|  | | If yes, are you trying for a pregnancy? | | | | | | | | | | | | | | | | | | | |  | | Yes | |  | | No | |
|  | | If not trying for a pregnancy list contraceptive or barrier method used: | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | Any discomfort with intercourse? | | | | | | | | | | | | | | | | | | | |  | | Yes | |  | | No | |
|  | | Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness? | | | | | | | | | | | | | | | | | | | |  | |  | |  | |  | |
|  | |  | | | | | | | | | | | | | | | | | | | |  | | Yes | |  | | No | |
| Personal Safety | | Do you live alone? | | | | | | | | | | | | | | | | | | | |  | | Yes | |  | | No | |
|  | | Do you have frequent falls? | | | | | | | | | | | | | | | | | | | |  | | Yes | |  | | No | |
|  | | Do you have vision loss? | | | | | | | | | | | | | | | | | | | |  | | Yes | |  | | No | |
|  | | Do you have hearing loss? | | | | | | | | | | | | | | | | | | | |  | | Yes | |  | | No | |
|  | | Do you have an Advance Directive and/or Living Will? | | | | | | | | | | | | | | | | | | | |  | | Yes | |  | | No | |
|  | | Would you like information on the preparation of these? | | | | | | | | | | | | | | | | | | | |  | | Yes | |  | | No | |
|  | | Physical and/or mental abuse have also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider? | | | | | | | | | | | | | | | | | | | |  | |  | |  | |  | |
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| FAMILY HEALTH HISTORY | | | | | | | |
|  | | | | | | | |
|  | Age | | Significant Health Problems |  | Age | | Significant Health Problems |
| Father |  | |  | Children | M  F |  |  |
| Mother |  | |  | M  F |  |  |
| Sibling | M  F |  |  | M  F |  |  |
| M  F |  |  | M  F |  |  |
| M  F |  |  | Grandmother Maternal |  | |  |
| M  F |  |  | Grandfather Maternal |  | |  |
| M  F |  |  | Grandmother Paternal |  | |  |
| M  F |  |  | Grandfather Paternal |  | |  |

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| **Please check any of the following symptoms that you have or have had in the last 30 days.** | |
| **Constitutional** | |  |  | | --- | --- | | Fever  Night Sweats  Significant weigh gain  Significant weight loss | Exercise intolerance  Sedation  Lethargy or malaise  Chills | |
| **Eyes** | |  |  | | --- | --- | | Wears glasses or contact lenses  Dry eyes  Irritation | Vision changes  Eye disease  Eye injury | |
| **ENMT** | Ears   |  |  | | --- | --- | | Difficulty hearing | Ear Pain |   Nose   |  |  | | --- | --- | | Frequent nose bleeds  Sinus problems | Nose problems |   Mouth/Throat   |  |  | | --- | --- | | Sore throat  Bleeding gums  Soring  Dry mouth  Oral abnormalities | Mouth ulcer  Teeth abnormalities  Mouth breathing  Ringing in the ears  Sinusitis | |
| **Cardiovascular** | |  |  | | --- | --- | | Chest pain on exertion  Arm pain on exertion  Shortness of breath when walking  Shortness of breath when lying down | Palpitations  Known heart murmur  Light-headed on standing  Ankle swelling | |
| **Respiratory** | |  |  | | --- | --- | | Cough  Wheezing  Shortness of breath | Coughing up blood  Sleep apnea | |
| **Gastrointestinal** | |  |  | | --- | --- | | Abdominal pain  Nausea  Vomiting  Constipation  Change in appetite | Black or tarry stools  Frequent diarrhea  Vomiting blood  Dyspepsia  GERD | |
| **Genitourinary** | |  |  | | --- | --- | | Urinary loss of control  Difficulty urinating  Increased urinary frequency | Hematuria (blood in your urine)  Incomplete emptying | |
| **Musculoskeletal** | |  |  | | --- | --- | | Muscle aches muscle weakness  Arthralgias/joint pain  Backpain  Swelling in extremities | Neck pain  Difficulty walking  Cramps  Osteoporosis  Fractures | |
| **Skin** | |  |  | | --- | --- | | Abnormal mole  Jaundice  Rash  Itching  Dry skin  Growths/lesions | Laceration  Non-healing areas  Changes in hair/nails  Psoriasis  Change in skin color  Breast lump | |
| **Neurologic** | |  |  | | --- | --- | | Loss of consciousness  Weakness  Numbness  Seizures  Dizziness  Frequent or severe headaches | Migraines  Restless legs  Tremor  Gait dysfunction  Paralysis | |
| **Psychiatric** | |  |  | | --- | --- | | Depression  Sleep disturbances  Feeling unsafe in relationship  Restless sleep  Alcohol abuse  Anxiety  Hallucinations | Suicidal thoughts  Mood swings  Memory loss  Agitation  Dementia  Delirium | |
| **Endocrine** | |  |  | | --- | --- | | Fatigue  Increased thirst  Hair loss | Increased hair growth  Cold intolerance | |
| **Hematologic/ Lymphatic** | |  |  | | --- | --- | | Swollen glands  Easy bruising  Excessive bleeding | Anemia  Phlebitis | |
| **Allergy/ Immunologic** | |  |  | | --- | --- | | Runny nose  Sinus pressure  Itching | Hives  Frequent sneezing | |

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| MENTAL HEALTH | | | | |
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| Is stress a major problem for you? |  | Yes |  | No |
| Do you feel depressed? |  | Yes |  | No |
| Do you panic when stressed? |  | Yes |  | No |
| Do you have problems with eating or your appetite? |  | Yes |  | No |
| Do you cry frequently? |  | Yes |  | No |
| Have you ever attempted suicide? |  | Yes |  | No |
| Have you ever seriously thought about hurting yourself? |  | Yes |  | No |
| Do you have trouble sleeping? |  | Yes |  | No |
| Have you ever been to a counselor? |  | Yes |  | No |

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| men and women |

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| Any urinary tract, bladder, kidney, or prostate infections within the last year? | Yes | No |
| Do you feel pain or burning with urination? | Yes | No |
| Any blood in your urine? | Yes | No |
| Any problems with control of urination? | Yes | No |
| Do you have any problems emptying your bladder completely? | Yes | No |
| Do you usually get up to urinate during the night? | Yes | No |
| If yes, how many times a night? | | |
| Date of last colonoscopy? | | |

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| WOMEN ONLY | | | | |
|  | | | | |
| Age at onset of menstruation: | | | | |
| Date of last menstruation: | | | | |
| Period every       days | | | | |
| Heavy periods, irregularity, spotting, pain, or discharge? |  | Yes |  | No |
| Number of pregnancies       Number of live births | | | | |
| Are you pregnant or breastfeeding? |  | Yes |  | No |
| Have you had a D&C, hysterectomy, or Cesarean? |  | Yes |  | No |
| Any hot flashes or sweating at night? |  | Yes |  | No |
| Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period? |  | Yes |  | No |
| Experienced any recent breast tenderness, lumps, or nipple discharge? |  | Yes |  | No |
| Date of last pap and rectal exam? | | | | |
| Date of last mammogram? | | | | |
|  | | | | |
| MEN ONLY | | | | |
|  | | | | |
| Do you feel burning discharge from penis? |  | Yes |  | No |
| Has the force of your urination decreased? |  | Yes |  | No |
| Any difficulty with erection or ejaculation? |  | Yes |  | No |
| Any testicle pain or swelling? |  | Yes |  | No |
| Date of last prostate and rectal exam? | | | | |
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| OTHER PROBLEMS | | | | |
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| Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain. | | | | |

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|  | Skin |  | Chest/Heart |  | Recent changes in: |
|  | Head/Neck |  | Back |  | Weight |
|  | Ears |  | Intestinal |  | Energy level |
|  | Nose |  | Bladder |  | Ability to sleep |
|  | Throat |  | Bowel |  | Other pain/discomfort: |
|  | Lungs |  | Circulation |  |  |

**ADDITIONAL NOTES:**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**