

Name:

Chart #

Y N Eyes

<input type="checkbox"/>	<input type="checkbox"/>	Previous surgery
<input type="checkbox"/>	<input type="checkbox"/>	Contact lens
<input type="checkbox"/>	<input type="checkbox"/>	Pain
<input type="checkbox"/>	<input type="checkbox"/>	Double vision
<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma
<input type="checkbox"/>	<input type="checkbox"/>	Cataract
<input type="checkbox"/>	<input type="checkbox"/>	Macular degeneration
<input type="checkbox"/>	<input type="checkbox"/>	Dry eyes
<input type="checkbox"/>	<input type="checkbox"/>	Flashes/Floaters

Y N Respiratory

<input type="checkbox"/>	<input type="checkbox"/>	Cough
<input type="checkbox"/>	<input type="checkbox"/>	Congestion
<input type="checkbox"/>	<input type="checkbox"/>	Wheezing
<input type="checkbox"/>	<input type="checkbox"/>	Asthma
<input type="checkbox"/>	<input type="checkbox"/>	Sleep apnea

Y N Blood/Lymph Nodes

<input type="checkbox"/>	<input type="checkbox"/>	Easy bruising
<input type="checkbox"/>	<input type="checkbox"/>	Gums bleed easily
<input type="checkbox"/>	<input type="checkbox"/>	Prolonged bleeding
<input type="checkbox"/>	<input type="checkbox"/>	Heavy aspirin use
<input type="checkbox"/>	<input type="checkbox"/>	Blood tranfusion

Y N Gastrointestinal

<input type="checkbox"/>	<input type="checkbox"/>	Heartburn
<input type="checkbox"/>	<input type="checkbox"/>	Nausea/Vomiting
<input type="checkbox"/>	<input type="checkbox"/>	Jaundice/Hepatitis

Y N Musculoskeletal

<input type="checkbox"/>	<input type="checkbox"/>	Stiffness
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis
<input type="checkbox"/>	<input type="checkbox"/>	Joint Pain/Swelling
<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid arthritis

Y N Ear, Nose, Throat

<input type="checkbox"/>	<input type="checkbox"/>	Hard of hearing
<input type="checkbox"/>	<input type="checkbox"/>	Ringing ears
<input type="checkbox"/>	<input type="checkbox"/>	Vertigo

Y N Genito-Urinary

<input type="checkbox"/>	<input type="checkbox"/>	Pain/Difficulty
<input type="checkbox"/>	<input type="checkbox"/>	Blood in urine
<input type="checkbox"/>	<input type="checkbox"/>	History of kidney stones
<input type="checkbox"/>	<input type="checkbox"/>	History of STD's
<input type="checkbox"/>	<input type="checkbox"/>	Syphilis

Y N Skin

<input type="checkbox"/>	<input type="checkbox"/>	Rash/Sores
<input type="checkbox"/>	<input type="checkbox"/>	Lesions
<input type="checkbox"/>	<input type="checkbox"/>	Hives/Eczema

Y N Cardiovascular

<input type="checkbox"/>	<input type="checkbox"/>	Chest pain
<input type="checkbox"/>	<input type="checkbox"/>	Dizziness
<input type="checkbox"/>	<input type="checkbox"/>	Fainting spells
<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath
<input type="checkbox"/>	<input type="checkbox"/>	Irregular heart beat
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty lying flat
<input type="checkbox"/>	<input type="checkbox"/>	Raynaud's syndrome
<input type="checkbox"/>	<input type="checkbox"/>	Hypertension

Y N Psychiatric

<input type="checkbox"/>	<input type="checkbox"/>	Anxiety/Depression
<input type="checkbox"/>	<input type="checkbox"/>	Mood swings
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty sleeping

Y N Neurological

<input type="checkbox"/>	<input type="checkbox"/>	Seizures
<input type="checkbox"/>	<input type="checkbox"/>	Weakness/Paralysis
<input type="checkbox"/>	<input type="checkbox"/>	Numbness
<input type="checkbox"/>	<input type="checkbox"/>	Tremors
<input type="checkbox"/>	<input type="checkbox"/>	Migraines
<input type="checkbox"/>	<input type="checkbox"/>	Multiple sclerosis

Y N Constitutional

<input type="checkbox"/>	<input type="checkbox"/>	Fatigue/Weakness
<input type="checkbox"/>	<input type="checkbox"/>	Fever
<input type="checkbox"/>	<input type="checkbox"/>	Weight Gain/Loss

Y N Endocrine

<input type="checkbox"/>	<input type="checkbox"/>	Increased thirst
<input type="checkbox"/>	<input type="checkbox"/>	Increased hunger
<input type="checkbox"/>	<input type="checkbox"/>	Increased urination
<input type="checkbox"/>	<input type="checkbox"/>	Increased sweating
<input type="checkbox"/>	<input type="checkbox"/>	Fingernail changes
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes mellitus
<input type="checkbox"/>	<input type="checkbox"/>	Thyroid disease

Y N Immunologic

<input type="checkbox"/>	<input type="checkbox"/>	Hives
<input type="checkbox"/>	<input type="checkbox"/>	Itching
<input type="checkbox"/>	<input type="checkbox"/>	Runny nose
<input type="checkbox"/>	<input type="checkbox"/>	Sinus pressure
<input type="checkbox"/>	<input type="checkbox"/>	Systemic lupus

If answered yes please explain: