

Please fill in the appropriate bubbles. Please stay inside the lines and fill the space completely. It is ok to use an ink pen for this sheet.

**GENERAL**

- Weight change             No             Gain             Loss  
Fatigue                     Yes             No  
Fever                       Yes             No  
Night sweats             Yes             No

**EYES**

- Double Vision             Yes             No  
Blurring of vision       Yes             No  
Flashes or blind spots    Yes             No  
Cataracts                  Yes             No

**NECK AND LUNGS**

- Change in voice          Yes             No  
Difficulty swallowing     Yes             No  
Ringing in ears          Yes             No  
Hearing loss              Yes             No  
Recent cold               Yes             No  
Shortness of breath      Yes             No  
Cough                      Yes             No

Email address: \_\_\_\_\_

Primary Care/ Family Doctor: \_\_\_\_\_

**GI**

- Stool Incontinence       Yes       No
- Diarrhea       Yes       No
- Constipation       Yes       No
- Nausea       Yes       No

**URINARY**

- Urinary incontinence       Yes       No
- Difficulty urinating       Yes       No

**MUSCULOSKELETAL**

- Joint stiffness       Yes       No
- Leg cramps       Yes       No
- Joint pain       Yes       No
- Joint swelling       Yes       No

**DERMATOLOGY**

- Rash       Yes       No
- Hives       Yes       No
- Dry skin       Yes       No

**NEUROLOGY**

- Headache             Yes         No
- Tingling  
or numbness         Yes         No
- Seizure              Yes         No
- Dizziness            Yes         No
- Memory problems  Yes         No
- Tremors              Yes         No

**MOOD**

- Depression          Yes         No
- Tension/stress      Yes         No
- Sleep disturbances  Yes         No
- Hyperactivity       Yes         No
- Anxiety              Yes         No
- Hallucinations      Yes         No

**ENDOCRINOLOGY**

- Excessive thirst     Yes         No
- Heat intolerance     Yes         No
- Cold intolerance     Yes         No
- Diabetes              Yes         No

**SOCIAL HISTORY**

- smoking     Yes     No     1 ppd     2 ppd
- alcohol     No     1-2 /week     1-2 /day     more than 1-2 per day
- drugs     Yes     No
- caffeine     No     1-2 /day     >2 /day
- working     Yes     No     Disabled
- marital status     Married     Single     Divorced     Widowed

**FAMILY HISTORY**

- Mother     Healthy     Nerve disease     Muscle Disease  
             High Blood pressure     Diabetes
- Father     Healthy     Nerve disease     Muscle Disease  
             High Blood pressure     Diabetes
- Grandparents     Healthy     Nerve disease     Muscle Disease  
                     High Blood pressure     Diabetes
- Siblings     Healthy     Nerve disease     Muscle Disease  
               High Blood pressure     Diabetes
- Children     Healthy     Nerve disease     Muscle Disease  
               High Blood pressure     Diabetes

**PERSONAL PAST MEDICAL HISTORY**

- High Blood Pressure     Yes     No
- Diabetes Mellitus     Yes     No
- Seizure disorder     Yes     No
- TIA/Stroke     Yes     No