Name: ***Chart #***

Y	N	***Eyes***
		Previous surgery
		Contact lens
		Pain
		Double vision
		Glaucoma
		Cataract
		Macular degeneration
		Dry eyes
		Flashes/Floaters

Y	N	***Ear, Nose, Throat***
		Hard of hearing
		Ringing ears
		Vertigo

Y	N	***Cardiovascular***
		Chest pain
		Dizziness
		Fainting spells
		Shortness of breath
		Irregular heart beat
		Difficulty lying flat
		Raynaud's syndrome
		Hypertension

Y	N	***Constitutional***
		Fatigue/Weakness
		Fever
		Weight Gain/Loss

Y	N	***Respiratory***
		Cough
		Congestion
		Wheezing
		Asthma
		Sleep apnea

Y	N	***Gastrointestinal***
		Heartburn
		Nausea/Vomiting
		Jaundice/Hepatitis

Y	N	***Genito-Urinary***
		Pain/Difficulty
		Blood in urine
		History of kidney stones
		History of STD's
		Syphilis

Y	N	***Psychiatric***
		Anxiety/Depression
		Mood swings
		Difficulty sleeping

Y	N	***Endocrine***
		Increased thirst
		Increased hunger
		Increased urination
		Increased sweating
		Fingernail changes
		Diabetes mellitus
		Thyroid disease

Y	N	***Blood/Lymph Nodes***
		Easy bruising
		Gums bleed easily
		Prolonged bleeding
		Heavy aspirin use
		Blood tranfusion

Y	N	***Muscoloskeletal***
		Stiffness
		Arthritis
		Joint Pain/Swelling
		Rheumatoid arthritis

Y	N	***Skin***
		Rash/Sores
		Lesions
		Hives/Eczema

Y	N	***Neurological***
		Seizures
		Weakness/Paralysis
		Numbness
		Tremors
		Migraines
		Multiple sclerosis

Y	N	***Immunologic***
		Hives
		Itching
		Runny nose
		Sinus pressure
		Systemic lupus

Smoking Status: YES / NO / Former smoker

Alcohol Use: YES / NO how much:___________________

Drugs: YES / NO Drugs Used:_____________________ How much__________________