Review of Physical Health

Do you have or have you recently had any of the following symptoms. Check all that may apply.

Constitutional

- ☐ Fatigue
- ☐ Fever
- ☐ Night Sweats

Heent

- ☐ Hearing Loss
- ☐ Sinus Problems
- ☐ Sore Throat

Respiratory

- ☐ Asthma
- ☐ Cough
- ☐ Wheezing

Cardiovascular

- ☐ Chest Pressure or Discomfort
- ☐ Irregular Heartbeat / Palpitations

Neurological

- ☐ Dizziness
- ☐ Headache

Gastrointestinal

- ☐ Constipation
- ☐ Diarrhea
- ☐ Heartburn
- ☐ Vomiting

Genitourinary

- ☐ Dysuria (Painful Urination)
- ☐ Hematuria (Blood in Urine)

Metabolic / Endocrine

- ☐ Cold Intolerance
- ☐ Heat Intolerance
- ☐ Polydipsia (Excessive Thirst)
- ☐ Polyphagia (Excessive Hunger)
- ☐ Polyuria (Frequent Urination)

Psychiatric

- ☐ Depressed Mood
- ☐ Emotional Changes
- ☐ Stress / Anxiety

Musculoskeletal

- ☐ Arthralgias (Joint Pain)
- ☐ Gait Disturbance (Difficult Walking)
- ☐ Joint Swelling
- ☐ Muscle Weakness

Hematologic / Lymphatic

- ☐ Easy Bleeding
- ☐ Bruising (Excessive)

Intequmentary

- ☐ Hives
- ☐ Rash
- ☐ Skin Lesion

Immunologic

- ☐ Environmental Allergies
- ☐ Seasonal Allergies
- ☐ Food Allergies

Family History

	Yes	No	Relationship
Blindness	◯	◯	_____
Cataract	◯	◯	_____
Crossed Eyes	◯	◯	_____
Glaucoma	◯	◯	_____
Macular Degeneration	◯	◯	_____
Retinal Detachment	◯	◯	_____

	Yes	No	Relationship
Heart Disease	◯	◯	_____
High Blood Pressure	◯	◯	_____
Kidney Disease	◯	◯	_____
Lupus	◯	◯	_____
Rheumatoid Arthritis	◯	◯	_____
Thyroid Disease	◯	◯	_____

Other Eye Disease	◯	◯	_____	Type: _____
Cancer	◯	◯	_____	Type: _____
Diabetes	◯	◯	_____	Type: _____

Print Form