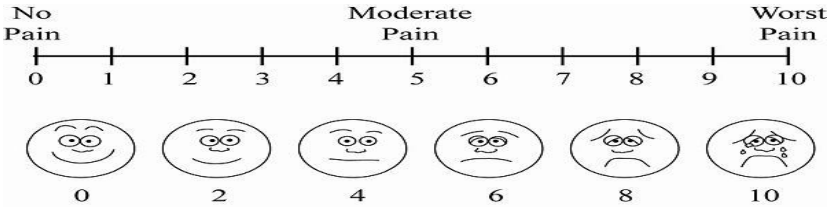
ONLY Answer Applicable Questions

Name _____
Date of Birth _____
Date _____

Medical History **Please be specific with you answers**
*****Use PAIN SCALE at the bottom of page to rate any pain questions.**

How has you health changed since your last visit (... if you have been seen before?) _____
_____
Headaches / Sinuses / Location of pain _____
Visual changes / Lights / Floaters / Pain _____
Hearing / Loss / Ringing / Tubes _____
Speech / Dyslexia / Etc._____
Memory _____
Facial Drooping / Numbness _____
Fatigue Level _____
Do you need assistance with daily activities? _____
Are you able to work (if employed)?_____
Presently, are you disabled? _____
Taste / Smell _____
Appetite / Special diet _____
Do you take Supplements? (List) _____
Lactose Intolerant / Gluten _____
Body temperature changes _____
Does weather change bother you? _____
Hair loss / Sores _____
Swallowing problems _____
Tongue / Throat / Glands _____
Dry eyes (rate to what degree) _____
Writing changes _____
Driving Skills _____
Coordination / Walking devices _____
Tremors / Seizures _____
Any type of rashes _____
Chest Pain / SOB / Cough _____
Irregular heart beats _____
Ever had an abnormal EKG_____
Nausea / Vomiting / Heartburn _____
Diarrhea / Constipation/ Abdominal Pain _____
Use of regular laxatives? _____
Unusual weight gain or loss _____
Breast problems _____
Bladder / Pain / Frequency _____
Menstrual / Vaginal Changes _____
Testical / Prostate _____
Testical pain _____
Loss of Libido _____
Sleeping problems / napping_____
Depression / Anxiety / Irritable _____
Do you see a Counselor / Psychiatrist? _____
Joint pain / swelling (be specific) _____
Muscle pain _____
Muscle twitching (fasciculation) _____
Do you have any joint deformities? _____
What medication help you? _____
Other symptoms not mentioned _____
_____
Are you thinking of applying for disability? _____
Have you discontinued any meds since last seen? _____



Signature _____