Name: _____ **MR#:** _____ **Date:** _____ **Pg. 1 of 2**

Filling out this form allows us to focus on special issues if needed during your office visit. Thanks!

1. Have there been any Hospitalization, Surgery, Fracture or Major Illness since the last visit? O Yes O No

2. Have there been any **NEW** School, Family, or Social Problems since the last visit? O Yes O No

3. Any Family members with new onset of diabetes, heart attack, stroke, cancer, thyroid disease, osteoporosis, pituitary or other hormone related problems since your last visit? O Yes O No

4. Have there been any chronic problems **(lasting more than two weeks)** that have **developed since the last visit?** (Please mark NONE per category if nothing applies)

General O **NONE**

Weight loss:	O Yes	O No
Excessive weight gain	O Yes	O No
Decreased appetite:	O Yes	O No
Increased appetite:	O Yes	O No
Fatigue:	O Yes	O No
Fever:	O Yes	O No
Excessive sweating:	O Yes	O No
Dizziness:	O Yes	O No

Gastrointestinal O **NONE**

Nausea:	O Yes	O No
Vomiting:	O Yes	O No
Abdominal pain:	O Yes	O No
Fullness or bloating:	O Yes	O No
Heartburn:	O Yes	O No
Blood in stool or black stool:	O Yes	O No
Constipation:	O Yes	O No
Diarrhea:	O Yes	O No

Endocrine O **NONE**

Heat Intolerance:	O Yes	O No
Cold Intolerance:	O Yes	O No
Breast changes:	O Yes	O No
Extreme Thirst:	O Yes	O No
Low Blood Sugar:	O Yes	O No
Increased ring and/or shoe size:	O Yes	O No

Eyes O **NONE**

Blurred Vision:	O Yes	O No
Bleeding in eyes or glaucoma:	O Yes	O No
Bulging of eyes:	O Yes	O No
Dryness of eyes:	O Yes	O No
Eye Pain:	O Yes	O No

HENT/Neck O **NONE**

Nose Bleeds:	O Yes	O No
Sore Throat:	O Yes	O No

HEENT/Neck cont'd

Chronic headaches:	O Yes	O No
Neck Pain:	O Yes	O No
Difficulty swallowing:	O Yes	O No
Change in voice:	O Yes	O No
Swollen lymph nodes:	O Yes	O No

Cardiovascular O **NONE**

Chest pain:	O Yes	O No
Racing heart rate:	O Yes	O No
Slow heart rate:	O Yes	O No
Palpitations/pounding heart:	O Yes	O No
Swollen legs:	O Yes	O No
Abnormal heart rhythm:	O Yes	O No
Tightness/pressure in chest:	O Yes	O No
Shortness of breath with activity:	O Yes	O No
Leg Pain with walking:	O Yes	O No

Respiratory O **NONE**

Shortness of breath:	O Yes	O No
Difficulty breathing:	O Yes	O No
Chronic cough:	O Yes	O No
Wheezing:	O Yes	O No

Skin O **NONE**

Nail changes:	O Yes	O No
Rashes:	O Yes	O No
Color changes:	O Yes	O No
Changes in elbow/neck area:	O Yes	O No
Acne changes:	O Yes	O No
Excessive hair growth:	O Yes	O No
Excessive hair loss:	O Yes	O No
Itching/dryness:	O Yes	O No
Easy bruising:	O Yes	O No
Prolonged bleeding:	O Yes	O No
New stretch marks:	O Yes	O No
Skin "tags":	O Yes	O No

Musculoskeletal ○ **NONE**

Joint pain:	○ Yes	○ No
Swelling/stiffness of joints:	○ Yes	○ No
Muscle cramps:	○ Yes	○ No
Back pain:	○ Yes	○ No
Weakness:	○ Yes	○ No
Recent change in height:	○ Yes	○ No
Fracture since the last visit:	○ Yes	○ No

Neurologic ○ **NONE**

Headaches:	○ Yes	○ No
Double vision:	○ Yes	○ No
Fainting spells:	○ Yes	○ No
Seizures:	○ Yes	○ No
Loss of sensation:	○ Yes	○ No
Trembling hands:	○ Yes	○ No
Confusion:	○ Yes	○ No
Slurred speech:	○ Yes	○ No
Tingling/numbness:	○ Yes	○ No
Pain in hands/feet:	○ Yes	○ No
Trouble walking:	○ Yes	○ No
Trouble with coordination:	○ Yes	○ No

Genitourinary ○ **NONE**

Blood in urine:	○ Yes	○ No
Incontinence:	○ Yes	○ No
Frequent urination:	○ Yes	○ No
Night time urination:	○ Yes	○ No
Weak urine stream:	○ Yes	○ No
Kidney stones:	○ Yes	○ No
Decreased kidney function:	○ Yes	○ No
Decreased sexual function:	○ Yes	○ No

Psychiatric ○ **NONE**

History of mental illness:	○ Yes	○ No
Anxiety or nervousness:	○ Yes	○ No
Depression:	○ Yes	○ No
Stress:	○ Yes	○ No
Insomnia:	○ Yes	○ No
Panic attacks:	○ Yes	○ No

Females ONLY - GYN ○ **NONE**

Irregular periods:	○ Yes	○ No
Lack of periods:	○ Yes	○ No
Breast discharge or fullness:	○ Yes	○ No
Painful intercourse:	○ Yes	○ No
Difficulty becoming pregnant:	○ Yes	○ No

Pediatrics ONLY ○ **NONE**

Decreased growth [height]:	○ Yes	○ No
Excessive growth [height]:	○ Yes	○ No
Delay in puberty:	○ Yes	○ No
More developed puberty:	○ Yes	○ No

Please list NEW medications or CHANGES to existing medications since last visit: (Include vitamins, herbs, aspirin, estrogens & contraceptives

	MEDICATION	DOSE	HOW OFTEN?
1.			
2.			
3.			
4.			
5.			

PLEASE GIVE THIS SHEET TO THE FRONT DESK BEFORE YOU ARE CALLED BACK TO A ROOM. PLEASE LET THE NURSE KNOW IF YOU NEED YOUR PRESCRIPTIONS REFILLED. We suggest you keep a list of medications with doses and frequency in your wallet or purse. Thanks again very much!

☐ **Yes, I need prescriptions.** ☐ **No prescriptions needed at this visit**

If yes: ☐ **30 day supply with refills, or** ☐ **90 day supply with refills.**

My pharmacy is: _____. ☐ **no change in pharmacy.**