REVIEW OF SYMPTOMS

DO YOU HAVE ANY PROBLEMS IN THE FOLLOWING AREAS? IF YES, CHECK PROBLEMS AND GIVE DETAILS OF EACH IN SECTION 22 BELOW.

9. **GENERAL** ☐ Fever ☐ Chills ☐ Nose ☐ Sinuses
☐ Excess Tiredness, Fatigue ☐ Headaches ☐ Faintness
☐ Sweats ☐ Weight Change ☐ Throat
☐ Other _____

10. **HEART, LUNGS**
☐ Last chest X-ray - When? _____ ☐ Last EKG - When? _____
☐ Cough, Wheezing or Asthma ☐ Chest Tightness: Pain
☐ Coughing Blood ☐ High Blood Pressure
☐ Irregular Heartbeat ☐ Shortness of Breath
☐ Other _____

11. **BREASTS** ☐Pain ☐ Lumps ☐ Regular Self-Exam ☐ Prior breast surgery

12. **STOMACH, DIGESTION**
☐ Constipation ☐ Indigestion
☐ Bloody or Black Stools ☐ Vomiting
☐ Rupture or Hernia ☐ Diarrhea
☐ Hemorrhoids ☐ Change in Bowel Habits
☐ Other _____

13. **KIDNEY, URINATION**
☐ Kidney or Bladder Infection ☐ Frequent Urination
☐ Kidney Stone ☐ Blood in Urine
☐ Pain with Urination ☐ Urination at Night
☐ Other _____

14. **INTEGUMENT** ☐ Skin ☐ Hair ☐ Nails

15. **SKELETAL** ☐ Bones ☐ Joints ☐ Muscles

16. **NERVES, EMOTIONS**
☐ History of Child Abuse ☐ Psychiatric Care or Counseling
☐ Confusion ☐ Suicide Attempts
☐ Depression ☐ Sleep Disorders or Problems
☐ Excess Anxiety ☐ Problems with Family Relationships

17. **SURGERY** Have you ever been advised to have a surgical operation which you have not undergone?
☐ Yes ☐ No If yes, explain _____

18. **SEX** Are you satisfied with your sexual relationships? ☐ Yes ☐ No
Do you have any problems or questions about sex that you would like to discuss with your doctor?
☐ Yes ☐ No
Have you ever had a sexual relationship with a person of the same sex? ☐ Yes ☐ No

19. **FOR MEN ONLY**
☐ Male surgery? Type _____ ☐ Weak or Slow Stream Urine
☐ Pain or Lump in Testicles ☐ Discharge from Penis
☐ Difficulty with Erection ☐ Sexually Transmitted Disease

20. **FOR WOMEN ONLY**
Length of Periods _____ days Date of last period _____ Age menstruation began _____
Age Menopause _____ Number of Pregnancies _____ Miscarriages/Abortions _____
☐ Date of Last Pap and Pelvic ☐ Are you Pregnant? ☐ Yes ☐ No
☐ Pain or Bleeding with Intercourse ☐ Bleeding Between Periods
☐ Irregular Periods, Severe Cramps ☐ Using Birth Control? Type _____
☐ Female Surgery? Type _____ ☐ Sexually Transmitted Disease
☐ Recurrent Vaginal Infection ☐ Other _____

21. **DO YOU HAVE ANY ILLNESS OR SYMPTOM NOT PREVIOUSLY MENTIONED IN THIS QUESTIONNAIRE?**
☐ Yes ☐ No
_____

22. **DETAILS REGARDING ABOVE**
_____
_____

PATIENT SIGNATURE _____ DATE _____