

PATIENT SYMPTOMS

Have you **recently** experienced any health problems from the list below? These answers may help us be of more help to you.

Problem	A Lot	Some	None at all
1. Pain	_____	_____	_____
• Headaches	_____	_____	_____
• Chest	_____	_____	_____
• Abdominal	_____	_____	_____
• Pelvic	_____	_____	_____
• Back	_____	_____	_____
• Joints or muscles	_____	_____	_____
2. Menstrual problems	_____	_____	_____
3. Hearing or vision problems	_____	_____	_____
4. Nervous (stress/anxiety/depression)	_____	_____	_____
5. Abuse (physical or emotional)	_____	_____	_____
6. Coughing or breathing problems	_____	_____	_____
7. Sleeping problems	_____	_____	_____
8. Sexual concerns	_____	_____	_____
9. Urine problems	_____	_____	_____
10. Bowel problems	_____	_____	_____
11. Skin problems	_____	_____	_____
12. Worried about yourself, children, family, birth defects, cancer	_____	_____	_____
13. Tired	_____	_____	_____
14. Medicines	_____	_____	_____
15. Eating problems: weight changes	_____	_____	_____
16. Life style: smoking, alcohol, drugs	_____	_____	_____

What special concerns do you have today?

NAME _____

DOB _____