Ira E. Bennett, D.P.M., F.A.C.F.A.S.

Patient name:____________________________________

Date:______________ Patient signature:____

CIRCLE ALL THAT APPLY TO YOU

Any Diseases of : Head Ears Eyes Nose Throat: type__________________________

GENERAL:
Fever Night sweats Weight loss Loss of appetite

HEENT:
Blurred vision Vision changes Sinus infections Mouth sores Loss or change of taste
Nose Bleeds

LYMPHATICS:
Lymph nodes Swollen glands HT_________________ WT______________

INTEGUMENT: BP_______________ Pulse_____________ Temp________
Skin disease Rashes

CENTRAL NERVOUS SYSTEM:
Memory loss Loss of concentration Loss of coordination Weakness Loss of strength
Sleep disturbances Emotional changes Mood Swings

CARDIOVASCULAR:
Chest Pain Palpitations Dizziness

PULMONARY:
Shortness of Breath Difficulty breathing Wheezing Cough Coughing up of blood

GASTROINTESTINAL:
Abdominal Pain Constipation Vomiting Nausea Jaundice Ulcer Discomfort after eating

GENITOURINARY:
Blood in Urine Painful urination Urination during the night Urgency in urination
Frequency of urination Kidney stones Urinary tract infections Sexually transmitted disease

MUSCULOSKELETAL:
Muscle pain Bone pain Joint pain

ENDOCRINOLOGY:
Heat intolerance Cold intolerance Difficulty in swallowing Excessive thirst