Name:_____ Date of Birth:___/___/____ Date:__/____/____

Since your last complete examination, do you have or have you had any symptoms that concern you related to any of the following:

	YES	NO
Frequent or severe headache		
Problems with your vision		
Problems with your hearing		
Nosebleeds		
Hay fever		
Mouth sores		
Bleeding gums		
Hoarseness		
Difficulty/pain swallowing		
Chest pain or tightness		
Shortness of breath		
Palpitations		
Persistent cough		
Nausea or vomiting		
Diarrhea		
Constipation		
Abdominal pain		
For women:		
Urinary leakage		
Pain with intercourse		
Other sexual problems		
For men:		
Difficulty beginning urinary stream		
Getting up to urinate more than one time per night		
Difficulty with getting or maintaining an erection		
For men and women:		
Joint pain or swelling		
Skin rashes		
Changes in moles or other spots on skin		
Anxiety or low mood interfering with function		
Do you feel threatened in any way?		

Please explain any yes answers or symptoms of concern noted above:

_____

_____

_____

_____

_____

THANK YOU FOR CHOOSING EAGLE FAMILY MEDICINE AT OAK RIDGE!!!

For office use only.

Reviewed by:_____