Name ______________________________ Reg. Number ______________________________

Please fill this form out completely while you wait

While you wait for your appointment, please take a few moments and answer these yes / no questions. The answers to these questions may assist your doctor in every aspect of your care, from diagnosis to treatment options. Use the extra space provided to let us know anything you think may be helpful or relevant to why you are here today. Don't worry about "answering a question wrong." If something is important your doctor will probably go over it with you during the appointment.

Circle "yes" to questions about symptoms you think you experience more than others, or often enough that you notice them; or for things that bother you. Answer "no" to questions about symptoms that you do not have or have rarely and are not bothersome. Thank you.

Eyes / Ears / Nose / Mouth / Throat:

Eye pain	yes	no
Double vision	yes	no
Blurry vision	yes	no
Loss of vision	yes	no
Loss of hearing	yes	no
Loss of smell / taste	yes	no
Mouth ulcers	yes	no
Dry mouth / eyes	yes	no
Swallowing pain	yes	no
Coughing / choking	yes	no

Head/Neck:

Headaches	yes	no
Swollen lymph nodes	yes	no
Head / brain injury	yes	no
Neck pain	yes	no

Respiratory:

Need to sleep sitting up	yes	no
Difficulties breathing	yes	no
Pain breathing	yes	no
Wheezes	yes	no
Intolerant of exercise	yes	no

Cardiac:

Chest pain	yes	no
Palpitations	yes	no
Irregular heart beat	yes	no

Integumentary / Skin:

Rashes	yes	no
Splitting / cracking skin	yes	no
Changes in fingernailsyes	no	

Genito-urinary:

Genital pain	yes	no
Painful urination	yes	no
Blood in urine	yes	no
History of "STDs"	yes	no
Frequent nighttime urination	yes	no
Impotence	yes	no
Incontinence of urine / stool	yes	no

Vascular:

Swollen feet / ankles / legs	yes	no
Loss of hair on legs	yes	no
Leg pain with exercise	yes	no
Color change of hands / feet	yes	no

Endocrine:

Feel too hot / cold all the time	yes	no
Too thirsty / hungry	yes	no
Weight loss / gain	yes	no
Breast pain	yes	no
Nipple discharge	yes	no
Frequent urination	yes	no

Musculoskeletal:

Joint pain	yes	no
Back pain	yes	no
Arm / Leg pain	yes	no
Limited arm / leg mobility	yes	no

Gastrointestinal:

Stomach pain	yes	no
Diarrhea / constipation	yes	no
Blood in stool	yes	no
Nausea / vomiting	yes	no