Patient Physician Partnership

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Patient Name: **Date:**

Do you have any of these symptoms (Mark "no" if no symptoms are present):

1. General	☐ No	☐Wt loss ☐Wt gain ☐Appetite loss ☐Fever ☐Decreased energy
2. Eyes	☐ No	☐Irritation ☐Discharge ☐Yellow color ☐Other
3. Ears	☐ No	☐Pain ☐Discharge ☐Other
4. Nose	☐ No	☐Runny nose ☐Congestion
5. Mouth	☐ No	☐Ulcers ☐Sore throat ☐Other
6. Cardiovascular	☐ No	☐Palpitations ☐Leg swelling ☐Fast heart rate ☐Other
7. Respiratory	☐ No	☐Wheezing ☐Shortness of breath ☐Cough ☐Other
8. Gastrointestinal	☐ No	☐Nausea ☐Vomiting ☐Constipation ☐Diarrhea ☐Jaundice ☐Pain ☐Blood on stool ☐Other
9. Urinary	☐ No	☐Blood in urine ☐Pain with urination ☐Frequent urination ☐Sudden need to urinate ☐Other
10. Musculoskeletal	☐ No	☐Weakness ☐Joint pain ☐Muscle Pain ☐Other
11. Skin	☐ No	☐Rash ☐Itching ☐Lesions/Ulcers ☐Other
12. Neurological	☐ No	☐Headache ☐Tingling/numbness ☐Seizure ☐Other
13. Psychiatric	☐ No	☐Depression ☐Anxiety ☐Behavior issues ☐Sleep Disturbances ☐Other
14. Endocrine	☐ No	☐Frequent urination ☐Excessive drinking of fluids ☐Heat/cold intolerance ☐Other
15. Heme/Lymph	☐ No	☐Bruises ☐Bleeding ☐Nosebleeds ☐Gums bleeding ☐Heavy menstrual periods (females only)
16. Allergy/Immun.	☐ No	☐Watery eyes ☐Eczema ☐Seasonal allergies ☐Other

Has a doctor ever told you that you have a problem with:

1. Your heart or blood vessels?	☐ No	☐ Yes	Details:____________________
2. Your lungs?	☐ No	☐ Yes	Details:____________________
3. Your stomach or other gastrointestinal organs?	☐ No	☐ Yes	Details:____________________
4. Your joints, muscles or bones?	☐ No	☐ Yes	Details:____________________
5. Your hormones or glands?	☐ No	☐ Yes	Details:____________________
6. Your nerves?	☐ No	☐ Yes	Details:____________________
7. Your liver or blood?	☐ No	☐ Yes	Details:____________________
8. Your skin or immune system?	☐ No	☐ Yes	Details:____________________
9. Any cancers?	☐ No	☐ Yes	Details:____________________
10. Other? ____________________			

(Continued on back) →→→→→→→→→→→→→→→→→→→→→→→→→→→→→→

Past surgeries (include year):

_____

_____

Has a family member had a problem with:

1. His/her heart or blood vessels? ☐ No ☐ Yes Details:_____
2. His/her lungs? ☐ No ☐ Yes Details:_____
3. His/her stomach or other gastrointestinal organs? ☐ No ☐ Yes Details:_____
4. His/her joints, muscles or bones? ☐ No ☐ Yes Details:_____
5. His/her hormones or glands? ☐ No ☐ Yes Details:_____
6. His/her nerves? ☐ No ☐ Yes Details:_____
7. His/her liver or blood? ☐ No ☐ Yes Details:_____
8. His/her skin or immune system? ☐ No ☐ Yes Details:_____
9. Any cancers? ☐ No ☐ Yes Details:_____
10. Other? _____

Current Medications:

Rx Name	Strength (mg)	Directions (times per day)

Drug Allergies:

_____

For Office Use Only

☐ **Reviewed with patient/family:** _____

Initial & Date