

GENERAL SYMPTOMS Check (✓) symptoms you currently have or have had in the past year.

<p>GENERAL</p> <p><input type="checkbox"/> Bruise easily</p> <p><input type="checkbox"/> Chills</p> <p><input type="checkbox"/> Dental problems</p> <p><input type="checkbox"/> Depression</p> <p><input type="checkbox"/> Difficulty sleeping</p> <p><input type="checkbox"/> Dizziness</p> <p><input type="checkbox"/> Fainting</p> <p><input type="checkbox"/> Fever</p> <p><input type="checkbox"/> Forgetfulness</p> <p><input type="checkbox"/> Headache</p> <p><input type="checkbox"/> Loss of sleep</p> <p><input type="checkbox"/> Loss of weight</p> <p><input type="checkbox"/> Nervousness</p> <p><input type="checkbox"/> Numbness</p> <p><input type="checkbox"/> Sweats</p> <p><input type="checkbox"/> Tiredness</p> <p><input type="checkbox"/> Weight gain</p> <p>GENITO-URINARY</p> <p><input type="checkbox"/> Blood in urine</p> <p><input type="checkbox"/> Frequent urination</p> <p><input type="checkbox"/> Lack of bladder control</p> <p><input type="checkbox"/> Painful urination</p>	<p>GASTROINTESTINAL</p> <p><input type="checkbox"/> Appetite poor</p> <p><input type="checkbox"/> Bloating</p> <p><input type="checkbox"/> Bowel changes</p> <p><input type="checkbox"/> Constipation</p> <p><input type="checkbox"/> Diarrhea</p> <p><input type="checkbox"/> Excessive hunger</p> <p><input type="checkbox"/> Excessive thirst</p> <p><input type="checkbox"/> Gas</p> <p><input type="checkbox"/> Hemorrhoids</p> <p><input type="checkbox"/> Indigestion</p> <p><input type="checkbox"/> Nausea</p> <p><input type="checkbox"/> Rectal bleeding</p> <p><input type="checkbox"/> Stomach pain</p> <p><input type="checkbox"/> Vomiting</p> <p><input type="checkbox"/> Vomiting blood</p> <p>CARDIOVASCULAR</p> <p><input type="checkbox"/> Chest pain</p> <p><input type="checkbox"/> High blood pressure</p> <p><input type="checkbox"/> Irregular heartbeat</p> <p><input type="checkbox"/> Low blood pressure</p> <p><input type="checkbox"/> Poor circulation</p> <p><input type="checkbox"/> Rapid heartbeat</p> <p><input type="checkbox"/> Swelling of ankles</p> <p><input type="checkbox"/> Varicose veins</p>	<p>EYE, EAR, NOSE, THROAT</p> <p><input type="checkbox"/> Bleeding gums</p> <p><input type="checkbox"/> Blurred vision</p> <p><input type="checkbox"/> Crossed eyes</p> <p><input type="checkbox"/> Difficulty swallowing</p> <p><input type="checkbox"/> Double vision</p> <p><input type="checkbox"/> Earache</p> <p><input type="checkbox"/> Ear discharge</p> <p><input type="checkbox"/> Hay fever</p> <p><input type="checkbox"/> Hoarseness</p> <p><input type="checkbox"/> Loss of hearing</p> <p><input type="checkbox"/> Nosebleeds</p> <p><input type="checkbox"/> Persistent cough</p> <p><input type="checkbox"/> Ringing in ears</p> <p><input type="checkbox"/> Sinus problems</p> <p><input type="checkbox"/> Vision - flashes</p> <p><input type="checkbox"/> Vision - halos</p> <p>SKIN</p> <p><input type="checkbox"/> Bruise easily</p> <p><input type="checkbox"/> Hives</p> <p><input type="checkbox"/> Itching</p> <p><input type="checkbox"/> Change in moles</p> <p><input type="checkbox"/> Rash</p> <p><input type="checkbox"/> Scars</p> <p><input type="checkbox"/> Sore that won't heal</p>	<p>MEN only</p> <p><input type="checkbox"/> Breast lump</p> <p><input type="checkbox"/> Erection difficulties</p> <p><input type="checkbox"/> Lump in testicles</p> <p><input type="checkbox"/> Penis discharge</p> <p><input type="checkbox"/> Sore on penis</p> <p><input type="checkbox"/> Other</p> <p>WOMEN only</p> <p><input type="checkbox"/> Abnormal pap smear</p> <p><input type="checkbox"/> Bleeding between periods</p> <p><input type="checkbox"/> Breast lump</p> <p><input type="checkbox"/> Extreme menstrual pain</p> <p><input type="checkbox"/> Hot flashes</p> <p><input type="checkbox"/> Nipple discharge</p> <p><input type="checkbox"/> Painful intercourse</p> <p><input type="checkbox"/> Vaginal discharge</p> <p><input type="checkbox"/> Other</p> <p>Date of last menstrual period _____</p> <p>Date of last pap smear _____</p> <p>_____</p> <p>Have you had a mammogram? _____</p> <p>Are you pregnant? _____</p> <p>Number of children _____</p>
---	---	---	---