

Jeffrey S. Nugent, MD
Maria R. Reyes, MD
Shelli-Marie Nelson, APRN
Cynthia Repella, APRN
Kelly Tran, APRN
Deborah Baker, APRN



8610 Technology Way Reno, NV 89521 * 3086 Silver Sage Drive Carson City, NV 89701
775-826-4900 • FAX 826-3257 • www.nevallergy.com

Hello,

Thank you for scheduling your initial office visit with our practice. See below for required check in times:

- Dr Jeffrey Nugent - Please check in **15 minutes** prior to your appointment time
- Dr Maria Reyes - Please check in **30 minutes** prior to your appointment time
- Shelli Marie Nelson, APRN - Please check in **15 minutes** prior to your appointment time
- Cynthia Repella, APRN - Please check in **15 minutes** prior to your appointment time
- Kelly Tran, APRN - Please check in **15 minutes** prior to your appointment time
- Deborah Baker, APRN – Please check in **15 minutes** prior to your appointment time

In addition to the enclosed paperwork, you will receive a text and/or email three business days prior to your appointment. In this text/email, there will be a link to complete the required virtual registration. **Please complete both the enclosed paperwork AND virtual registration prior to checking in for your appointment. If one or more component is not complete at the time of check in, we will need to reschedule your appointment.**

Because we are a specialist, we ask that you call your insurance before arriving for your appointment to check your benefits for allergy testing and treatment.

We may be able to perform allergy testing at this appointment depending on time allowed in our schedule and your insurance coverage. In order to be prepared for this possible testing, please refrain from taking any medication containing an antihistamine for five (5) days prior to your appointment.

Please do not hesitate to call if you have any questions. We are looking forward to seeing you!

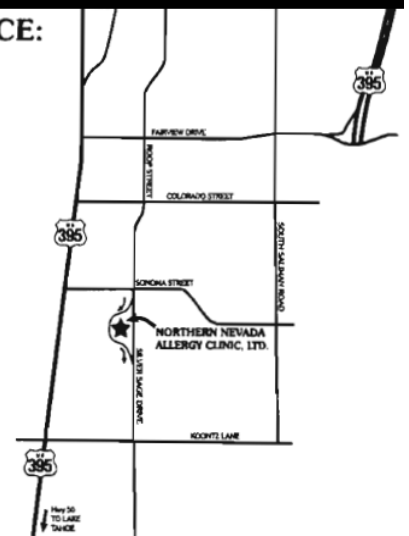
Sincerely yours,

Northern Nevada Allergy Staff

RENO OFFICE:
8610 Technology Way
Reno, NV 89521



CARSON CITY OFFICE:
3086 Silver Sage Drive
Carson City, NV 89701



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Date: _____

Patient's Name: _____ Date of Birth: _____
First Middle initial Last

Gender: _____ Age: _____ Marital Status: _____ Occupation: _____ City of Residence: _____

Who / How were you referred to our practice? _____

Who is your Primary Healthcare Physician/Provider? _____

Person completing this form, if other than patient: _____ / _____
Relationship to patient

Would you like medical records from your evaluation with us sent to: Primary Care provider above Referring provider above Other: _____

What is the main problem that has brought you in for evaluation?

How long ago did these symptoms FIRST BEGIN?

What treatments have you tried?

What helped the most?

DRUG ALLERGIES: List, or write "none"

MEDICATIONS:

First, please list medications taken for any ALLERGY-RELATED (Respiratory, nasal, eye, skin, etc) conditions:

Medication Name	Dosage:	Times per day:	How long used:	Effectiveness:
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

ALL other medications, or herbal supplements taken for ANY OTHER CONDITIONS: (include over-the-counter / as needed):

_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Symptoms and Contributory History

NOSE AND SINUSES:	None	Mild	Moderate	Severe	Remarks:
Itchy nose	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Rubbing the nose	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Sneezing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Stuffy nose / nasal congestion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Runny or drippy nose	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Drainage into throat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Thick or thin?					
Frequent throat clearing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Sleeping with mouth open	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Snoring	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Decreased sense of smell	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Rate your sense of smell from 0-10: (0 being none, and 10 being normal): _____ out of 10					
Facial pressure or pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Headache	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Itchy / scratchy throat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Lump or "frog" in throat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Thick green or yellow nasal mucus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Hoarseness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Loss of voice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
History of broken nose / nasal trauma?	<input type="checkbox"/> No			<input type="checkbox"/> Yes	
Recurrent sinus infections?	<input type="checkbox"/> No			<input type="checkbox"/> Yes	
Frequency:					
CT (cat scan) of the sinuses?	<input type="checkbox"/> No			<input type="checkbox"/> Yes	
Ever told you have Nasal Polyps?	<input type="checkbox"/> No			<input type="checkbox"/> Yes	
CT (cat scan) of the sinuses?	<input type="checkbox"/> No			<input type="checkbox"/> Yes	
Have you been evaluated previously by an ENT (Ear, Nose, Throat) Doctor?	<input type="checkbox"/> No			<input type="checkbox"/> Yes	
Who?					
Details					
Last seen:					
Previous nasal or sinus surgery?	<input type="checkbox"/> No			<input type="checkbox"/> Yes	
Details:					
Tonsils or adenoids removed?	<input type="checkbox"/> No			<input type="checkbox"/> Yes	Which/ when:
EYES:					
Itchy eyes or rubbing of eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Burning eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Watery eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Red / Bloodshot eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Swelling around eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Darkness under eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Eyelids stick together	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
DO YOU WEAR CONTACTS:	<input type="checkbox"/> No			<input type="checkbox"/> Yes	
Last eye exam:					
Ophthalmologist?					
EARS:					
Itching of ear canals or outer ear	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Ear stuffiness, fullness or pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Ear popping or clicking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Difficulty "clearing ears"	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Decreased hearing acuity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Dizziness / Vertigo	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Ear infections? Frequency, details:					
Ear surgery or tubes? When, details:					

LUNGS / BREATHING:	None	Mild	Moderate	Severe	Remarks:
Cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Chest Tightness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Are these symptoms CONTINUOUS Or do they occur in EPISODES?	<input type="checkbox"/> Continuous		<input type="checkbox"/> Episodes		
Do the above symptoms limit your activity level?	<input type="checkbox"/> No		<input type="checkbox"/> Yes		How often:
Do these symptoms wake you at night?	<input type="checkbox"/> No		<input type="checkbox"/> Yes		How often:
Have you been diagnosed with asthma?	<input type="checkbox"/> No		<input type="checkbox"/> Yes		
Have you been diagnosed with COPD, emphysema, or chronic bronchitis?	<input type="checkbox"/> No		<input type="checkbox"/> Yes		
Are you currently using any inhalers or nebulizers to help you breathe easier?	<input type="checkbox"/> No		<input type="checkbox"/> Yes		
Have you used any inhalers in the past?	<input type="checkbox"/> No		<input type="checkbox"/> Yes		
Have you been given oral steroids for breathing symptoms (ie Prednisone, Medrol)	<input type="checkbox"/> No		<input type="checkbox"/> Yes		How often: Last given:
Have you required Emergency Room care for breathing symptoms?	<input type="checkbox"/> No		<input type="checkbox"/> Yes		How often: Last ER visit:
Have you been hospitalized for breathing symptoms?	<input type="checkbox"/> No		<input type="checkbox"/> Yes		How often: Last Hospitalized:
Have you had any pulmonary function (breathing) testing?	<input type="checkbox"/> No		<input type="checkbox"/> Yes		Details:
Have you ever had a Chest Xray?	<input type="checkbox"/> No		<input type="checkbox"/> Yes		
Last done:	Findings:				

SKIN / RASHES	None	Mild	Moderate	Severe	Remarks:
Hives (red, raised, itchy blotches)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Swelling of the skin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Eczema / Atopic dermatitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Contact dermatitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Itching WITHOUT any rash	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other rash / not sure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Does it itch?	<input type="checkbox"/> No		<input type="checkbox"/> Yes		
Does it burn or hurt?	<input type="checkbox"/> No		<input type="checkbox"/> Yes		
Are there bumps?	<input type="checkbox"/> No		<input type="checkbox"/> Yes		
Are there blisters?	<input type="checkbox"/> No		<input type="checkbox"/> Yes		
How long has it been present	___ days ___ weeks ___ months				
Is this a CONTINUOUS rash or does it come and go in EPISODES?	<input type="checkbox"/> Continuous		<input type="checkbox"/> Episodes		
How long to individual lesions last?	___ hours ___ days ___ weeks				
Where does the rash START?					
What body part(s) are affected?					
Do any of the following make the rash worse:					
Dry Skin?	<input type="checkbox"/> No		<input type="checkbox"/> Yes		
Heat (ie hot tubs, heaters)?	<input type="checkbox"/> No		<input type="checkbox"/> Yes		
Exercise?	<input type="checkbox"/> No		<input type="checkbox"/> Yes		
Cold?	<input type="checkbox"/> No		<input type="checkbox"/> Yes		
Foods?	<input type="checkbox"/> No		<input type="checkbox"/> Yes		List:
Any relation to meals?	<input type="checkbox"/> No		<input type="checkbox"/> Yes		
Medications?	<input type="checkbox"/> No		<input type="checkbox"/> Yes		
Other triggers you suspect:					

Have you seen any other dermatologist or allergist for this?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Who? Last seen?
If Yes- what evaluation was done?			
What treatments have you tried?			
<input type="checkbox"/> Antihistamines- less sedating: (Claritin, zyrtec, allegra, etc)			Effectiveness:
<input type="checkbox"/> Antihistamines- sedating: (benadryl, atarax/hydroxyzine,etc)			Effectiveness:
<input type="checkbox"/> Topical Steroids (triamcinolone, mometasone, etc)			
<input type="checkbox"/> Protopic ointment or Elidel cream			Effectiveness:
<input type="checkbox"/> Other: list:			Effectiveness:
Have you received oral steroids (ie Prednisone or medrol) for this?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Response: Last taken: Number of times taken:
Have you received a steroid shot (ie kenalog, depo-medrol) for this?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Response: Last taken: Number of times taken:
Other information you feel is relevant:			

FOOD ALLERGIES:			Remarks:
Do you have any known or suspected food allergies:	<input type="checkbox"/> No	<input type="checkbox"/> Yes	If YES, list the foods, and the reactions below:
FOOD #1: _____			
Reaction:			
How treated:			
Eaten since?			
FOOD #2: _____			
Reaction:			
How treated:			
Eaten since?			
FOOD #3: _____			
Reaction:			
How treated:			
Eaten since?			
Avoiding any foods in your diet now?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Which ones:
Do you have an EPIPEN or TWINJECT (auto-injectable epinephrine device)?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	

STINGING INSECT ALLERGY:			
Do you have any known or suspected allergies to stinging insects (ie bees/ wasps / yellow jackets?):	<input type="checkbox"/> No	<input type="checkbox"/> Yes	If YES, list the reactions below:
How long ago were you stung?			
What stung you (if known?):			
Where were you stung?			
Reaction / Treatment:			
Were you ever allergy tested for this?			
Other relevant information?			
Do you have an EPIPEN or TWINJECT (auto-injectable epinephrine device)?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	

TRIGGERS: Which of the following make your symptoms worse? Mark all that apply

	Nasal, Ear, or Eye symptoms	Breathing symptoms	Skin symptoms	Remarks:
Worse indoors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Worse outdoors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Grass	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
leaves / mulch / compost / hay	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Cats	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Dogs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other animals (specify) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Upper respiratory infections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Tobacco smoke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Strong odors or perfumes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Chemical vapors or aerosol sprays	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Dust	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Weather changes / humidity changes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Cold air	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Stress or strong emotions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Sunlight or sun exposure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Alcohol ingestion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Cosmetics- specify:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Foods- specify:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Relation to menstrual cycle	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Taking NSAID medications such as Motrin (ibuprofen/advil), naprosyn or aspirin?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Have you taken any of these before? How often / last taken:				
Other triggers : (specify)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Seasons: Spring	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Summer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Fall	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Winter	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
ALL YEAR	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Have you been previously tested for allergies?

If YES: Year _____ City _____ Doctor _____

- Skin tested for environmental allergies: (Findings):
- Blood tested for environmental allergies:(Findings):

-
- Skin tested for food allergies (Findings):
 - Blood tested for food allergies (Findings):

-
- Patch tested for contact dermatitis (Findings):

Have you been on allergy shots?

If YES: When were you started on shots?

How long were you on shots?

Last received? Did they help?

Did you have any reactions to the shots?

SMOKING HISTORY:

Never Smoked
 In the past, but I quit → # years smoked: _____ # packs per day _____ When did you quit? _____
 I Currently Smoke: → # years smoked: _____ # packs per day _____

ALCOHOLIC BEVERAGE HABITS:

HOUSING / ENVIRONMENT: Check the things that are true about your home:

Type of Building:		Heating and Cooling:		Your BEDROOM:	
<input type="checkbox"/>	Single family home	<input type="checkbox"/>	Radiators	<input type="checkbox"/>	Carpeted
<input type="checkbox"/>	Apartment/ condo/ dormitory	<input type="checkbox"/>	Central forced heating	<input type="checkbox"/>	Hard floor (wood, tile, etc)
<input type="checkbox"/>	Mobile home	<input type="checkbox"/>	A/C- central forced air	<input type="checkbox"/>	Curtains
<input type="checkbox"/>	Farm / Ranch	<input type="checkbox"/>	A/C- window unit(s)	<input type="checkbox"/>	Feather or down comforter
<input type="checkbox"/>	Mainly wall-to-wall carpet	<input type="checkbox"/>	Humidifiers used	<input type="checkbox"/>	Have dust mite-proof covers on pillows
<input type="checkbox"/>	Mainly hard-surface flooring	<input type="checkbox"/>	DE-humidifiers used	<input type="checkbox"/>	Have dust mite-proof covers on mattress

Approximate age of home:
How long have you lived there?

Number of stories:

Basement?

Number of occupants:

Any smokers?

Who?

Does their smoking affect your symptoms?

PETS:

Type (cat, dog, bird, etc)	Number	How long present:	indoors / outdoors	Any symptoms caused by close contact?
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

OCCUPATIONAL INFLUENCES: (do any occupational influences / exposures impact your symptoms? Describe:

ACTIVITIES: Describe your hobbies / social / athletic activities:

Do any of these cause an increase in your symptoms?

GEOGRAPHIC HISTORY: Please list localities, where you have lived, how long you lived there, and relation to symptoms

City, State	Duration	Remarks about allergy symptoms:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

FAMILY HISTORY:

Father	<input type="checkbox"/> Alive	<input type="checkbox"/> Deceased	<input type="checkbox"/> Unknown	Age/cause of death:
Mother	<input type="checkbox"/> Alive	<input type="checkbox"/> Deceased	<input type="checkbox"/> Unknown	Age/cause of death:
Brothers (#)	<input type="checkbox"/> Alive	<input type="checkbox"/> Deceased	<input type="checkbox"/> Unknown	Age(s) /cause(s) of death:
Sisters (#)	<input type="checkbox"/> Alive	<input type="checkbox"/> Deceased	<input type="checkbox"/> Unknown	Age(s) /cause(s) of death:

Do you have family members (blood relatives) with:	Mother	Father	Brother	Sister	Son	Daughter	Grand-parent
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
COPD / Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nasal Allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Sinusitis or Nasal Polyps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cystic Fibrosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Migraines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Food Allergy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eczema or Atopic Dermatitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Recurrent Hives / Swelling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Immune Deficiency	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

PAST MEDICAL HISTORY: List other medical problems / issues you have (ie high blood pressure, back pain, etc):

PAST SURGICAL HISTORY: List any surgery or hospitalizations you have had:

ADDITIONAL REVIEW OF SYSTEMS: (check all that apply)

Conditions	Details if Yes:	Symptoms	Details if Yes:
<input type="checkbox"/> Head trauma		<input type="checkbox"/> Fever	
<input type="checkbox"/> Heart disease / angina		<input type="checkbox"/> Severe fatigue	
<input type="checkbox"/> Irregular heart rate / rhythm		<input type="checkbox"/> Depression / Anxiety	
<input type="checkbox"/> Heart murmur		<input type="checkbox"/> Vision Change	
<input type="checkbox"/> High blood pressure		<input type="checkbox"/> Muscle Ache	
<input type="checkbox"/> High cholesterol		<input type="checkbox"/> Joint Pain	
<input type="checkbox"/> Ulcer / Gastritis		<input type="checkbox"/> Bowel Habit Changes	
<input type="checkbox"/> Esophageal reflux		<input type="checkbox"/> Abdominal Pain	
<input type="checkbox"/> Chronic diarrhea		<input type="checkbox"/> Vomiting	
<input type="checkbox"/> Hepatitis		<input type="checkbox"/> Painful Urination	
<input type="checkbox"/> Bladder infections		<input type="checkbox"/> Lymph node swelling	
<input type="checkbox"/> Kidney / renal disease		<input type="checkbox"/> Night Sweats	
<input type="checkbox"/> Arthritis		<input type="checkbox"/> Easy Bruising / Bleeding	
<input type="checkbox"/> Other bone / joint problems		<input type="checkbox"/> Passing out	
<input type="checkbox"/> Osteoporosis		<input type="checkbox"/> Heat / Cold intolerance	
<input type="checkbox"/> Diabetes / blood sugar		<input type="checkbox"/> Unintentional weight gain/loss	
<input type="checkbox"/> Thyroid condition		<input type="checkbox"/> Numbness/ weakness	
<input type="checkbox"/> Stroke		<input type="checkbox"/> Other Pain	