Name: _____ **Date:** _____

Thomas E. Lipin, M.D.

Are You Currently Or Do You Regularly Experience:

*Please circle **Yes** or **No**.*

CONSTITUTIONAL

Weight Loss	Yes or No
Fever	Yes or No
Fatigue	Yes or No
Problems Sleeping	Yes or No

NOSE

Nasal Obstruction	Yes or No
Decreased Sense of Smell	Yes or No
Nasal Discharge	Yes or No
Nasal Congestion	Yes or No
Nasal Pain	Yes or No
Nose Bleeding	Yes or No
Postnasal Drip	Yes or No
Snoring	Yes or No

CARDIOVASCULAR

Chest Pain	Yes or No
High Blood Pressure	Yes or No
Palpitations	Yes or No
Heart Murmur	Yes or No

RESPIRATORY (LUNGS)

Shortness of Breath	Yes or No
Cough	Yes or No
Wheezing	Yes or No
Coughing Blood	Yes or No
Bronchiectasis	Yes or No
Chronic Bronchitis	Yes or No
Asthma	Yes or No
Lung Cancer	Yes or No
COPD	Yes or No

EYES

Blurred Vision	Yes or No
Eye Pain	Yes or No
Double Vision	Yes or No

EARS

Ringing in Ears	Yes or No
Itching in Ear	Yes or No
Ear Discharge	Yes or No
Hearing Loss	Yes or No
Ear Pain	Yes or No
Ear Fullness	Yes or No
Pressure Sensation	Yes or No
Vertigo/Dizziness	Yes or No

THROAT, MOUTH & SINUS

Sore throat	Yes or No
Difficulty Swallowing	Yes or No
Hoarseness	Yes or No
Neck Tenderness	Yes or No
Frequently Throat Clearing	Yes or No
Sinus Pain	Yes or No
Sleep Apnea	Yes or No
Swollen Glands	Yes or No
Change in Voice	Yes or No
Lump in Throat Sensation	Yes or No
Mouth Pain	Yes or No
Dentures	Yes or
Headaches	Yes or No

GENITOURINARY

Urgency	Yes or No
Frequently	Yes or No
Pain When Urinating	Yes or No
Renal Failure	Yes or No

Name: _____ **Date:** _____

GASTROINTESTINAL (STOMACH)

Nausea	Yes or No
Difficulty Swallowing	Yes or No
Excessive Belching	Yes or No
Vomiting	Yes or No
Painful Swallowing	Yes or No
Heartburn/Acid Reflux	Yes or No
Hepatitis	Yes or No

NEUROLOGICAL (NERVES)

Tremors	Yes or No
Migraines	Yes or No
Loss of Balance	Yes or No
Dementia	Yes or No
Seizures	Yes or No
Tingling or Numbness	Yes or No

ENDOCRINE

Cold Intolerance	Yes or No
Heat Intolerance	Yes or No
Loss of Hair	Yes or No
Weight Gain	Yes or No
Weight Loss	Yes or No
Diabetes	Yes or No
Hot Flashes	Yes or No

INTEGUMENTAR (SKIN)

New Skin Lesions	Yes or No
Changes to Existing Lesions	Yes or No
Pigmentation Changes	Yes or No

MUSCULOSKELETAL

Joint Pain	Yes or No
Muscle Pain	Yes or No
Joint Swelling	Yes or No
Rheumatoid Arthritis	Yes or No
Osteoporosis	Yes or No
Goiter	Yes or No

PSYCHIATRIC

Anxiety	Yes or No
Depression	Yes or No
Difficulty Sleeping	Yes or No

HEMATOLOGIC/LYMPH NODES

Easy Bleeding	Yes or No
Easy Bruising	Yes or No

ALLERGIC/IMMUNOLOGIC

Reaction to Anesthesia	Yes or No
Itchy Watery Burning Eyes	Yes or No
Sneezing	Yes or No

SKIN

Rash	Yes or No
Skin Cancer	Yes or No

SMOKE

Yes or No How Much_____

DRINK (ALCOHOL)

Yes or No How Much_____