



<b>ENDOCRINE:</b>		YES	NO		YES	NO
INCREASED URINATION / THIRST.....	<input type="checkbox"/>	<input type="checkbox"/>	DIABETES.....	<input type="checkbox"/>	<input type="checkbox"/>	
LOW BLOOD PRESSURE.....	<input type="checkbox"/>	<input type="checkbox"/>	NUMBER OF YEARS _____			
UNEXPLAINED WEIGHT LOSS/GAIN.....	<input type="checkbox"/>	<input type="checkbox"/>	CONTROLLED BY:			
THYROID PROBLEMS.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> ORAL MEDS	<input type="checkbox"/> INJECTION		
<b>RESPIRATORY:</b>		YES	NO		YES	NO
CHRONIC COUGH.....	<input type="checkbox"/>	<input type="checkbox"/>	LUNG PROBLEMS/ASTHMA/TB.....	<input type="checkbox"/>	<input type="checkbox"/>	
WHEEZING /SHORT OF BREATH.....	<input type="checkbox"/>	<input type="checkbox"/>	COPD /EMPHYSEMA.....	<input type="checkbox"/>	<input type="checkbox"/>	
SLEEP APNEA.....	<input type="checkbox"/>	<input type="checkbox"/>	HOME OXYGEN USE.....	<input type="checkbox"/>	<input type="checkbox"/>	
WEAR C-PAP.....	<input type="checkbox"/>	<input type="checkbox"/>	BRONCHITIS/PNEUMONIA.....	<input type="checkbox"/>	<input type="checkbox"/>	
<b>CARDIOVASCULAR:</b>		YES	NO		YES	NO
BLOOD CLOTS.....	<input type="checkbox"/>	<input type="checkbox"/>	MURMUR/PALPATATIONS/VALVE DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	
CHEST PAIN / ANGINA.....	<input type="checkbox"/>	<input type="checkbox"/>	HIGH BLOOD PRESSURE.....	<input type="checkbox"/>	<input type="checkbox"/>	
CONGESTIVE HEART FAILURE.....	<input type="checkbox"/>	<input type="checkbox"/>	SHORTNESS OF BREATH.....	<input type="checkbox"/>	<input type="checkbox"/>	
ATRIAL FIB/ ARRHYTHMIA.....	<input type="checkbox"/>	<input type="checkbox"/>	HIGH CHOLESTEROL.....	<input type="checkbox"/>	<input type="checkbox"/>	
HEART CATH / STENTS.....	<input type="checkbox"/>	<input type="checkbox"/>	HEART ATTACK.....	<input type="checkbox"/>	<input type="checkbox"/>	
IF YES, WHEN ____/____/____			IF YES, WHEN ____/____/____			
STRESS TEST.....	<input type="checkbox"/>	<input type="checkbox"/>	BYPASS/OPEN HEART SURGERY.....	<input type="checkbox"/>	<input type="checkbox"/>	
PACEMAKER.....	<input type="checkbox"/>	<input type="checkbox"/>	PERIPHERAL VASCULAR DISEASE.....	<input type="checkbox"/>	<input type="checkbox"/>	
<b>NEUROLOGICAL:</b>		YES	NO		YES	NO
HEADACHES / MIGRAINES.....	<input type="checkbox"/>	<input type="checkbox"/>	ANXIETY / DEPRESSION.....	<input type="checkbox"/>	<input type="checkbox"/>	
SEIZURES / CONVULSIONS.....	<input type="checkbox"/>	<input type="checkbox"/>	STROKE/PARALYSIS/WEAKNESS.....	<input type="checkbox"/>	<input type="checkbox"/>	
ALZHEIMERS/DEMENTIA.....	<input type="checkbox"/>	<input type="checkbox"/>	PSYCHIATRIC DISORDER.....	<input type="checkbox"/>	<input type="checkbox"/>	
PARKINSONS / TREMORS.....	<input type="checkbox"/>	<input type="checkbox"/>	CLAUSTROPHOBIA.....	<input type="checkbox"/>	<input type="checkbox"/>	
DIZZINESS/VERTIGO/FAINTING.....	<input type="checkbox"/>	<input type="checkbox"/>	CAROTID ARTERY DISEASE.....	<input type="checkbox"/>	<input type="checkbox"/>	
<b>GASTROINTESTINAL:</b>		YES	NO		YES	NO
ULCER.....	<input type="checkbox"/>	<input type="checkbox"/>	LIVER PROBLEMS/ CIRRHOSIS.....	<input type="checkbox"/>	<input type="checkbox"/>	
HEPATITIS.....	<input type="checkbox"/>	<input type="checkbox"/>	BLACK/BLOODY STOOLS.....	<input type="checkbox"/>	<input type="checkbox"/>	
CIRCLE ONE TYPE: A B C			ACID REFLUX/HEARTBURN/HIATAL HERNIA	<input type="checkbox"/>	<input type="checkbox"/>	
<b>GENITOURINARY</b>		YES	NO		YES	NO
INCONTINENCE.....	<input type="checkbox"/>	<input type="checkbox"/>	KIDNEY PROBLEMS.....	<input type="checkbox"/>	<input type="checkbox"/>	
HESITANCY / DECREASE STREAM.....	<input type="checkbox"/>	<input type="checkbox"/>	DIALYSIS	<input type="checkbox"/>	<input type="checkbox"/>	
PAINFUL URINATION.....	<input type="checkbox"/>	<input type="checkbox"/>	PROSTATE PROBLEMS.....	<input type="checkbox"/>	<input type="checkbox"/>	
			PROSTATE MEDICATION	<input type="checkbox"/>	<input type="checkbox"/>	
<b>MUSCULOSKELETAL</b>		YES	NO		YES	NO
ARTHRITIS.....(OSTEO).....	<input type="checkbox"/>	<input type="checkbox"/>	PAIN / MISALIGNMENT.....	<input type="checkbox"/>	<input type="checkbox"/>	
RHEUMATOID ARTHRITIS .....	<input type="checkbox"/>	<input type="checkbox"/>	CAN YOU LIE FLAT?.....	<input type="checkbox"/>	<input type="checkbox"/>	
CHRONIC PAIN.....	<input type="checkbox"/>	<input type="checkbox"/>	DECREASED RANGE OF MOTION.....	<input type="checkbox"/>	<input type="checkbox"/>	
LUPUS.....	<input type="checkbox"/>	<input type="checkbox"/>	HEAD/SPINAL INJURY.....	<input type="checkbox"/>	<input type="checkbox"/>	
<b>HEMATOLOGIC</b>						
SICKLE CELL DISEASE.....	<input type="checkbox"/>	<input type="checkbox"/>	TEMPORAL ARTERY DISEASE.....	<input type="checkbox"/>	<input type="checkbox"/>	
HISTORY OF BLOOD CLOTS.....	<input type="checkbox"/>	<input type="checkbox"/>	ANEMIA.....	<input type="checkbox"/>	<input type="checkbox"/>	
EXCESSIVE BLEEDING/BRUISING.....	<input type="checkbox"/>	<input type="checkbox"/>	HIV / AIDS.....	<input type="checkbox"/>	<input type="checkbox"/>	