

Interim Clinical History

Stressors

Given the list of categories below, how much stress is each one causing you?

| | None | Mild | Moderate | Severe |
|---------------|------|------|----------|--------|
| Family | | | | |
| Friends | | | | |
| Relationships | | | | |
| Educational | | | | |
| Economic | | | | |
| Occupational | | | | |
| Housing | | | | |
| Legal | | | | |
| Health | | | | |

Side Effects

Please list any side effects you are noticing with your medications, and note whether they are mild, moderate, or severe:

Review of Systems:

Please note any physical symptoms you have experienced in the last several days:

| Constitutional | Eyes | Ears, Nose, Mouth, and Throat |
|---|---|--|
| <input type="checkbox"/> Chronic pain | <input type="checkbox"/> Eye pain | <input type="checkbox"/> Earache |
| <input type="checkbox"/> Loss of appetite | <input type="checkbox"/> Eye discharge | <input type="checkbox"/> Tinnitus (Ringing in ears) |
| <input type="checkbox"/> Increase in appetite | <input type="checkbox"/> Eye redness | <input type="checkbox"/> Decreased hearing or hearing loss |
| <input type="checkbox"/> Unexplained weight loss | <input type="checkbox"/> Blurred or double vision | <input type="checkbox"/> Frequent ear infections |
| <input type="checkbox"/> Weight gain | <input type="checkbox"/> Visual change | <input type="checkbox"/> Frequent nose bleeds |
| <input type="checkbox"/> Fatigue/Lethargy | <input type="checkbox"/> History of eye surgery | <input type="checkbox"/> Sinus congestion |
| <input type="checkbox"/> Unexplained fever | <input type="checkbox"/> Sensitivity to light | <input type="checkbox"/> Runny nose/Post-nasal drip |
| <input type="checkbox"/> Hot or Cold spells | <input type="checkbox"/> Scotomas (Blind spots) | <input type="checkbox"/> Difficulty swallowing |
| <input type="checkbox"/> Night sweats | <input type="checkbox"/> Retinal hemorrhage (Floaters in vision) | <input type="checkbox"/> Frequent sore throat |
| <input type="checkbox"/> Sleeping pattern disruption | <input type="checkbox"/> Amaurosis fugax (Feeling like a curtain is pulled over vision) | <input type="checkbox"/> Prolonged hoarseness |
| <input type="checkbox"/> Malaise (Flu-like or Vague sick feeling) | | <input type="checkbox"/> Pain in jaw or tooth |
| | | <input type="checkbox"/> Dry mouth |
| Other: <input style="width: 100%;" type="text"/> | Other: <input style="width: 100%;" type="text"/> | Other: <input style="width: 100%;" type="text"/> |

| Cardiovascular | Respiratory | Musculoskeletal |
|---|---|---|
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Pain with breathing | <input type="checkbox"/> Swelling in joints |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Chronic cough | <input type="checkbox"/> Redness of joints |
| <input type="checkbox"/> Palpitations (fast or irregular heartbeat) | <input type="checkbox"/> Chronic shortness of breath | <input type="checkbox"/> Other joint pains or stiffness |
| <input type="checkbox"/> Swollen feet or hands | <input type="checkbox"/> Chronic wheezing/Asthma | <input type="checkbox"/> Muscle pain or cramping |
| <input type="checkbox"/> Fainting spells | <input type="checkbox"/> Excessive phlegm | <input type="checkbox"/> Muscle weakness |
| | <input type="checkbox"/> Coughing blood | <input type="checkbox"/> Muscle stiffness |
| <input type="checkbox"/> Shortness of breath with exercise | <input type="checkbox"/> Nocturnal Dyspnea (Shortness of breath at night) | <input type="checkbox"/> Decreased range of motion |
| | | <input type="checkbox"/> Back pain or stiffness |
| | | <input type="checkbox"/> History of fractures |
| | | <input type="checkbox"/> Past injury to spine or joints |
| Other: <input type="text"/> | Other: <input type="text"/> | Other: <input type="text"/> |

| Gastrointestinal | | |
|---|--|--|
| <input type="checkbox"/> Excessive flatulence or belching | <input type="checkbox"/> Heartburn | <input type="checkbox"/> Change in appearance of stool |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Difficulty swallowing solids or liquids | <input type="checkbox"/> Blood in stool |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Recent loss in appetite | <input type="checkbox"/> Dark/Tarry stool |
| <input type="checkbox"/> Persistent nausea/vomiting | <input type="checkbox"/> Sensitivity to milk products | <input type="checkbox"/> Loss of bowel control |
| <input type="checkbox"/> Abdominal Pain | <input type="checkbox"/> Jaundice (yellow skin) | |
| Other: <input type="text"/> | | |

| Allergic/Immunologic | Endocrine | Hematologic/Lymphatic |
|--|--|---|
| <input type="checkbox"/> Frequent infections | <input type="checkbox"/> Severe menopausal symptoms | <input type="checkbox"/> Blood clots |
| <input type="checkbox"/> Hives | <input type="checkbox"/> Cold or heat intolerance | <input type="checkbox"/> Easy bleeding after surgery or dental work |
| <input type="checkbox"/> Anaphylactic reaction | <input type="checkbox"/> Excessive appetite | <input type="checkbox"/> History of blood transfusion |
| | <input type="checkbox"/> Excessive thirst or urination | <input type="checkbox"/> Excessive bruising or bleeding |
| | <input type="checkbox"/> Excessive sweating | <input type="checkbox"/> Swollen glands (neck, armpits, groin) |
| Other: <input type="text"/> | Other: <input type="text"/> | Other: <input type="text"/> |

| Genitourinary (General) | Genitourinary (Women) | Genitourinary (Men) |
|--|---|--|
| <input type="checkbox"/> Loss of urine control | <input type="checkbox"/> Unusual vaginal discharge | <input type="checkbox"/> Slow urine stream |
| <input type="checkbox"/> Painful/Burning urination | <input type="checkbox"/> Vaginal pain, bleeding, soreness, or dryness | <input type="checkbox"/> Scrotal pain |
| <input type="checkbox"/> Blood in urine | <input type="checkbox"/> Genital sores | <input type="checkbox"/> Lump or mass in the testicles |
| <input type="checkbox"/> Increased frequency of urination | <input type="checkbox"/> Heavy or irregular periods | <input type="checkbox"/> Abnormal penis discharge |
| <input type="checkbox"/> Up more than twice/night to urinate | <input type="checkbox"/> No menses (Periods stopped) | <input type="checkbox"/> Trouble getting/maintaining erections |
| <input type="checkbox"/> Urine retention | <input type="checkbox"/> Currently pregnant | <input type="checkbox"/> Inability to ejaculate/orgasm |
| <input type="checkbox"/> Frequent urine infections | <input type="checkbox"/> Sterility/Infertility | <input type="checkbox"/> Any other sexual or sex organ concerns |
| | <input type="checkbox"/> Any other sexual or sex organ concerns | |
| Other: <input type="text"/> | Other: <input type="text"/> | Other: <input type="text"/> |
| Neurological | Integumentary (Skin/Breast and Hair) | Psychiatric |
| <input type="checkbox"/> Paralysis | <input type="checkbox"/> Lesions | <input type="checkbox"/> In-depth review of psychiatric system appears earlier in document |
| <input type="checkbox"/> Fainting spells or blackouts | <input type="checkbox"/> Unusual mole | <input type="checkbox"/> Feeling depressed |
| <input type="checkbox"/> Dizziness/Vertigo | <input type="checkbox"/> Easy bruising | <input type="checkbox"/> Difficulty concentrating |
| <input type="checkbox"/> Drowsiness | <input type="checkbox"/> Increased perspiration | <input type="checkbox"/> Phobias/Unexplained fears |
| <input type="checkbox"/> Slurred speech | <input type="checkbox"/> Rashes | <input type="checkbox"/> No pleasure from life anymore |
| <input type="checkbox"/> Speech problems (other) | <input type="checkbox"/> Chronic dry skin | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Short term memory trouble | <input type="checkbox"/> Itchy skin or scalp | <input type="checkbox"/> Insomnia |
| <input type="checkbox"/> Memory difficulties (loss) | <input type="checkbox"/> Hair or nail changes | <input type="checkbox"/> Excessive moodiness |
| <input type="checkbox"/> Frequent headaches | <input type="checkbox"/> Hair loss | <input type="checkbox"/> Stress |
| <input type="checkbox"/> Muscle weakness | <input type="checkbox"/> Breast tenderness | <input type="checkbox"/> Disturbing thoughts |
| <input type="checkbox"/> Numbness/Tingling sensations | <input type="checkbox"/> Breast discharge | <input type="checkbox"/> Manic episodes |
| <input type="checkbox"/> Neuropathy (numbness in feet) | <input type="checkbox"/> Breast lump or mass | <input type="checkbox"/> Confusion |
| <input type="checkbox"/> Tremor in hands/shaking | | <input type="checkbox"/> Memory loss |
| <input type="checkbox"/> Muscle spasms or tremors | | |
| Other: <input type="text"/> | Other: <input type="text"/> | Other: <input type="text"/> |