_____
Registration Number

_____
(Last Name, First Name)

Current Visit Information

Thank you for taking time to fill out this form. It provides us with vital information. Please fill it out as completely as possible but realize that you are not obligated to answer any questions which you feel are intrusive or not relevant to your healthcare.

Have you been seen by a Decorah Clinic Physician any where in the last 3 years (including Mabel Clinic or elsewhere)? ___ Yes ___ No

Date of Birth_____ Phone ( )_____Pharmacy_____

A. Systems Review----------

Please **(X)** each symptom that you have experienced in the **past few months**. Indicate "NONE" (at the end of the list) if you have not experienced any of the symptoms listed in each group. **In the past few months, have you had:**

____Fever within the last month

____Enlarged glands (lymph nodes)

____Abnormal nipple discharge

____Breast lump

____Skin Problems

____Change of a mole

____Significant headaches

____Slurred speech

____Hoarseness

____Double vision

____Blurred vision

____Changes in hearing

____Depression

____Anxiety/nervousness

____Dizziness or fainting

____Sinus problems

____Shortness of breath

____Coughing or wheezing

____Coughed up sputum or blood

____Difficulty moving an arm or leg

____Abnormal swelling in the legs or feet

____Pain in the calves of your legs when you walk

____Chest pain/pressure/tightness

____Abnormal heart beat

____Difficulty swallowing

____Heartburn

____Weight gain or loss

____Abdominal or pelvic pain

____Urine leakage

____Abnormal periods

____Burning or pain when urinating

____Difficulty starting or stopping your urinary stream

____Getting up at night to urinate

____Excessive urination

____Frequent urination

____Blood in urine

____Difficulty completely emptying your bladder

____Stomach trouble

____Nausea or vomiting

____Change in bowel movements

____Blood in your bowel movement

____Excessive thirst

____Change in sexual drive or performance

____Erection problems

____Sleep disturbance

____Joint pain, stiffness or swelling

____Muscle pain or stiffness

____Back pain or stiffness

____Awakened at night with shortness of breath

____Exposure to anyone with tuberculosis (TB)

____Last Menstrual Period Date_____

____ Alcohol
# of servings per day_____

____ Tobacco
Amount per day_____

____Other

____NONE

Patient Signature_____ Date_____

Physician Signature_____ Date_____