

General	Gastrointestinal
Fatigue level: (Not tired) 0-10 (Exhausted)	Dyspepsia (indigestion) / heart burn / reflux <input type="checkbox"/> Yes <input type="checkbox"/> No
Appetite <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor	Nausea or vomiting <input type="checkbox"/> Yes <input type="checkbox"/> No
Total weight loss in last 6 mo. #: <input type="checkbox"/> Yes <input type="checkbox"/> No	Abdominal pain. Location: <input type="checkbox"/> Yes <input type="checkbox"/> No
Fevers / chills / night sweats <input type="checkbox"/> Yes <input type="checkbox"/> No	Diarrhea <input type="checkbox"/> Yes <input type="checkbox"/> No
Eyes	Constipation <input type="checkbox"/> Yes <input type="checkbox"/> No
Blurred Vision <input type="checkbox"/> Yes <input type="checkbox"/> No	Change in stool. <input type="checkbox"/> Yes <input type="checkbox"/> No
Double Vision <input type="checkbox"/> Yes <input type="checkbox"/> No	Bleeding or blood in stool (bright red vs black) <input type="checkbox"/> Yes <input type="checkbox"/> No
Ears, Nose, Mouth, Throat	* Feeding tube. # cans of /day <input type="checkbox"/> Yes <input type="checkbox"/> No
Hearing loss: (circle) R / L / Both sides <input type="checkbox"/> Yes <input type="checkbox"/> No	Genitourinary
Ear pain <input type="checkbox"/> Yes <input type="checkbox"/> No	Dysuria (pain or burning) <input type="checkbox"/> Yes <input type="checkbox"/> No
ringing in ears <input type="checkbox"/> Yes <input type="checkbox"/> No	Hematuria (blood in urine) <input type="checkbox"/> Yes <input type="checkbox"/> No
Sinus drainage <input type="checkbox"/> Yes <input type="checkbox"/> No	Problem starting, maintaining, completing urine flow <input type="checkbox"/> Yes <input type="checkbox"/> No
Difficulty breathing through nose <input type="checkbox"/> Yes <input type="checkbox"/> No	* Urinary incontinence / leakage <input type="checkbox"/> Yes <input type="checkbox"/> No
Nose bleeds <input type="checkbox"/> Yes <input type="checkbox"/> No	* Frequency, urgency, getting up at night to urinate <input type="checkbox"/> Yes <input type="checkbox"/> No
Last dentist visit: When:	Pain with intercourse <input type="checkbox"/> Yes <input type="checkbox"/> No
Sores on tongue or gums <input type="checkbox"/> Yes <input type="checkbox"/> No	FEMALE. Vaginal sores, nodules or lumps <input type="checkbox"/> Yes <input type="checkbox"/> No
Pain or difficulty chewing <input type="checkbox"/> Yes <input type="checkbox"/> No	FEMALE. Irregular vaginal bleeding or discharge <input type="checkbox"/> Yes <input type="checkbox"/> No
Odynophagia (pain on swallowing) throat/chest <input type="checkbox"/> Yes <input type="checkbox"/> No	MALE. Erectile Dysfunction <input type="checkbox"/> Yes <input type="checkbox"/> No
* Dysphagia (difficulty swallowing) <input type="checkbox"/> Yes <input type="checkbox"/> No	MALE. Mass, lump or pain with testicles <input type="checkbox"/> Yes <input type="checkbox"/> No
Hoarseness or change in voice <input type="checkbox"/> Yes <input type="checkbox"/> No	Breast
Lumps on neck. How long: <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you perform self breast examinations <input type="checkbox"/> Yes <input type="checkbox"/> No
Cardiovascular/Respiratory	Mass, lump, or pain in breast <input type="checkbox"/> Yes <input type="checkbox"/> No
Chest pain. Ch. Wall, sternum, rib cage, heart <input type="checkbox"/> Yes <input type="checkbox"/> No	Nipple discharge / inversion <input type="checkbox"/> Yes <input type="checkbox"/> No
Cough <input type="checkbox"/> Yes <input type="checkbox"/> No	Neurologic
Hemoptysis (coughing up blood) Amount: <input type="checkbox"/> Yes <input type="checkbox"/> No	Headaches <input type="checkbox"/> Yes <input type="checkbox"/> No
* Dyspnea. At rest, with activity <input type="checkbox"/> Yes <input type="checkbox"/> No	Vertigo (dizziness) <input type="checkbox"/> Yes <input type="checkbox"/> No
Do you use oxygen <input type="checkbox"/> Yes <input type="checkbox"/> No	Syncope (fainting) <input type="checkbox"/> Yes <input type="checkbox"/> No
Integumentary	Ataxia (lack of coordination) <input type="checkbox"/> Yes <input type="checkbox"/> No
Jaundice <input type="checkbox"/> Yes <input type="checkbox"/> No	Changes in speech <input type="checkbox"/> Yes <input type="checkbox"/> No
Edema. Location: <input type="checkbox"/> Yes <input type="checkbox"/> No	Change in memory/concentration <input type="checkbox"/> Yes <input type="checkbox"/> No
Skin rashes or itching. Location: <input type="checkbox"/> Yes <input type="checkbox"/> No	Seizures. Frequency: <input type="checkbox"/> Yes <input type="checkbox"/> No
* Open wounds or sores. Location: <input type="checkbox"/> Yes <input type="checkbox"/> No	Musculoskeletal
Nodules or lumps. Location: <input type="checkbox"/> Yes <input type="checkbox"/> No	* Arthritis. Location: <input type="checkbox"/> Yes <input type="checkbox"/> No
Healing incision. Location: <input type="checkbox"/> Yes <input type="checkbox"/> No	* Weakness. Location: <input type="checkbox"/> Yes <input type="checkbox"/> No
* Vascular access. Type: Location: <input type="checkbox"/> Yes <input type="checkbox"/> No	* Numbness. Location: <input type="checkbox"/> Yes <input type="checkbox"/> No
Immunologic	Recent falls <input type="checkbox"/> Yes <input type="checkbox"/> No
Autoimmune disorder. Type: <input type="checkbox"/> Yes <input type="checkbox"/> No	* Use an assistive device. Type: <input type="checkbox"/> Yes <input type="checkbox"/> No

Completed by: _____

Date: _____ * Patient may qualify for home health care.