CONNECTICUT HEALTH CARE ASSOCIATES

SYSTEM REVIEW: PLEASE CHECK THE APPROPRIATE BOX: FOR EACH PROBLEM CHECK NEVER, PAST OR NOW. PAST MEANS ANYTIME LONGER THAN SIX MONTHS AGO.

NEVER	PAST	NOW	HAVE YOU EVER HAD:
			GENERAL/CONSTITUTIONAL:
☐	☐	☐	Unexplained weight loss or weight gain
☐	☐	☐	Excessive fatigue
☐	☐	☐	Prolonged fever/chills
☐	☐	☐	Other:
			HEAD/EYES/EARS/NOSE/THROAT:
☐	☐	☐	Frequent or severe headaches
☐	☐	☐	Wear glasses or contact lenses
☐	☐	☐	Chronic nasal discharge, drainage or sneezing
☐	☐	☐	Impaired hearing
☐	☐	☐	When was your last eye exam?
☐	☐	☐	Other:
			NEUROLOGICAL:
☐	☐	☐	Memory loss
☐	☐	☐	Fainting, dizziness, seizures, convulsions
☐	☐	☐	Other:
			CARDIOVASCULAR
☐	☐	☐	Rheumatic Fever
☐	☐	☐	Pain or pressure in chest/Angina
☐	☐	☐	Any heart trouble
☐	☐	☐	Palpitation or pounding heat
☐	☐	☐	Abnormal heart rhythm or murmur
☐	☐	☐	Swelling of ankles
☐	☐	☐	High blood pressure
☐	☐	☐	Other:
			RESPIRATORY
☐	☐	☐	Chronic cough
☐	☐	☐	Asthma or wheezing
☐	☐	☐	Shortness of breath at night
☐	☐	☐	Shortness of breath
☐	☐	☐	Other:
			GASTROINTESTINAL
☐	☐	☐	Abdominal pain
☐	☐	☐	Loss of appetite
☐	☐	☐	Change in bowel habits (constipation or diarrhea)
☐	☐	☐	Noted blood in stool
☐	☐	☐	Hemorrhoids or rectal disease
☐	☐	☐	Other:
			GENITOURINARY
☐	☐	☐	Frequent urination at night
☐	☐	☐	Frequent or painful urination
☐	☐	☐	Difficulty holding urine
☐	☐	☐	Difficulty stopping or starting urine stream
☐	☐	☐	Urinary tract infection
			MALE
☐	☐	☐	Sores or discharge from penis
☐	☐	☐	Lump on or pain of testicle
☐	☐	☐	Sexually transmitted disease
☐	☐	☐	Condom use
☐	☐	☐	Problems with sexual function

NEVER	PAST	NOW	HAVE YOU EVER HAD:
			MUSCULOSKELETAL
☐	☐	☐	Pain in joints/arthritis
☐	☐	☐	Chronic back pain or injury
☐	☐	☐	Other:
			SKIN/BREAST
☐	☐	☐	Change or new growth in mole
☐	☐	☐	Breast lump
☐	☐	☐	Breast nipple discharge
☐	☐	☐	Other:
			EMOTIONAL
☐	☐	☐	Do you have trouble sleeping
☐	☐	☐	Are you often depressed
☐	☐	☐	Are you often anxious or nervous
☐	☐	☐	Ever had loss of memory
☐	☐	☐	Other:
			OPTIONAL
☐	☐	☐	Are you sexually active
☐	☐	☐	Are you sexually active with members of opposite sex ☐, same sex ☐, or both ☐.
☐	☐	☐	If sexually active with the opposite sex, do either of you use contraception (birth control?) If yes what form?
			HEMATOLOGIC/LYMPH
☐	☐	☐	Anemia
☐	☐	☐	Excessive bleeding or abnormal bruising
☐	☐	☐	A transfusion
☐	☐	☐	Any swelling of lymph nodes
☐	☐	☐	Other:
			ENDOCRINE
☐	☐	☐	Cold or heat intolerance, any thyroid problems
☐	☐	☐	Excessive thirst or hunger
☐	☐	☐	Other:
			FEMALE
☐	☐	☐	Method of birth control if sexually active/heterosexual
☐	☐	☐	Mid-cycle bleeding
☐	☐	☐	Pain with intercourse
☐	☐	☐	Vaginal discharge or sores
☐	☐	☐	Painful periods
☐	☐	☐	Sexually transmitted disease
☐	☐	☐	Problem with sexual function
☐	☐	☐	Are your periods regular
☐	☐	☐	Have you ever been pregnant

REVIEWED _____ DATE _____

REVIEWED _____ DATE _____

REVIEWED _____ DATE _____

NAME: _____ DOB: _____ DATE: _____