Southeast Medical Clinic Intake Form

*Please select **YES** for symptoms you have experienced **IN THE PAST MONTH***

General

Weight change	**O**	**Yes**	**O**	**No**
Loss of appetite	**O**	**Yes**	**O**	**No**
Fever	**O**	**Yes**	**O**	**No**
Weakness	**O**	**Yes**	**O**	**No**

Neurology

Headache	**O**	**Yes**	**O**	**No**
Tingling numbness	**O**	**Yes**	**O**	**No**
Seizure	**O**	**Yes**	**O**	**No**
Involuntary urine	**O**	**Yes**	**O**	**No**
Involuntary stool	**O**	**Yes**	**O**	**No**
Memory loss	**O**	**Yes**	**O**	**No**

Endocrinology

Tiredness	**O**	**Yes**	**O**	**No**
Excessive sweating	**O**	**Yes**	**O**	**No**
Excessive thirst	**O**	**Yes**	**O**	**No**
Low blood sugar	**O**	**Yes**	**O**	**No**
High blood sugar	**O**	**Yes**	**O**	**No**

Dermatology

Rash	**O**	**Yes**	**O**	**No**
Change in color of moles	**O**	**Yes**	**O**	**No**
Lumps	**O**	**Yes**	**O**	**No**

Ophthalmology

Diminished vision	**O**	**Yes**	**O**	**No**
Eye irritation	**O**	**Yes**	**O**	**No**
Drainage from eyes	**O**	**Yes**	**O**	**No**
Blurring of vision	**O**	**Yes**	**O**	**No**

ENT/respiratory

Cold	**O**	**Yes**	**O**	**No**
Cough	**O**	**Yes**	**O**	**No**
Coughing blood	**O**	**Yes**	**O**	**No**
Nose bleeds	**O**	**Yes**	**O**	**No**
Hearing loss	**O**	**Yes**	**O**	**No**
Change in voice	**O**	**Yes**	**O**	**No**
Sore throat	**O**	**Yes**	**O**	**No**
Ringing in ears	**O**	**Yes**	**O**	**No**
Short of breath	**O**	**Yes**	**O**	**No**
Pain in ears	**O**	**Yes**	**O**	**No**
Sinus congestion	**O**	**Yes**	**O**	**No**

Cardiology

Chest pain	**O**	**Yes**	**O**	**No**
Palpitations	**O**	**Yes**	**O**	**No**
Leg swelling	**O**	**Yes**	**O**	**No**
Dizziness	**O**	**Yes**	**O**	**No**
Short of breath	**O**	**Yes**	**O**	**No**

Printed Name: _____Date of Birth: _____

FILL OUT BOTH SIDES

Southeast Medical Clinic Intake Form

*Please select **YES** for symptoms you have experienced **IN THE PAST MONTH***

Gastro Enterology

Nausea	**O**	**Yes**	**O**	**No**
Heartburn	**O**	**Yes**	**O**	**No**
Vomiting	**O**	**Yes**	**O**	**No**
Bloating/belching	**O**	**Yes**	**O**	**No**
Difficulty swallowing	**O**	**Yes**	**O**	**No**
Abdominal pain	**O**	**Yes**	**O**	**No**
Diarrhea	**O**	**Yes**	**O**	**No**
Constipation	**O**	**Yes**	**O**	**No**
Change in bowel habits	**O**	**Yes**	**O**	**No**
Blood in stool	**O**	**Yes**	**O**	**No**

Musculoskeletal

Joint swelling	**O**	**Yes**	**O**	**No**
Joint pain	**O**	**Yes**	**O**	**No**
Leg cramps	**O**	**Yes**	**O**	**No**
Joint stiffness	**O**	**Yes**	**O**	**No**
Low back pain	**O**	**Yes**	**O**	**No**
Neck pain	**O**	**Yes**	**O**	**No**

Psychology

Tension/stress	**O**	**Yes**	**O**	**No**
Depression	**O**	**Yes**	**O**	**No**
Sleep disturbances	**O**	**Yes**	**O**	**No**

Genitourinary (Please fill all that apply)

Heavy periods	**O**	**Yes**	**O**	**No**
Vaginal bleeding	**O**	**Yes**	**O**	**No**
Irregular periods	**O**	**Yes**	**O**	**No**
Painful periods	**O**	**Yes**	**O**	**No**
Vaginal discharge	**O**	**Yes**	**O**	**No**
Hot flashes	**O**	**Yes**	**O**	**No**
Blood in urine	**O**	**Yes**	**O**	**No**
Urinary incontinence	**O**	**Yes**	**O**	**No**
Urinary urgency	**O**	**Yes**	**O**	**No**
Difficulty urinating	**O**	**Yes**	**O**	**No**
Increased urinary Frequency	**O**	**Yes**	**O**	**No**
Difficulty with erection	**O**	**Yes**	**O**	**No**
Difficulty with ejaculation	**O**	**Yes**	**O**	**No**

If there is anything not listed that you'd like to discuss with your provider, please share in the provided space:

Printed Name: _____Date of Birth: _____

FILL OUT BOTH SIDES