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 female

Heavy periods	O	Yes	O	No
Blood in urine	O	Yes	O	No
Difficulty urinating	O	Yes	O	No
Increased urinary frequency	O	Yes	O	No
Urinary incontinence	O	Yes	O	No
Urinary urgency	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

Genitourinary male

Increased urinary frequency	O	Yes	O	No
Urinary urgency	O	Yes	O	No
Difficulty urinating	O	Yes	O	No
Blood in urine	O	Yes	O	No
Difficulty with erection	O	Yes	O	No
	O	Yes	O	No
Difficulty with ejaculation	O	Yes	O	No

Printed Name: _____ Date of Birth: _____

V1.2

FILL OUT BOTH SIDES

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: _____

V1.2

FILL OUT BOTH SIDES