

## COMPLETE PHYSICAL QUESTIONNAIRE

Please check the items that apply to you and bring this sheet to your office visit.

- Fatigue
- Trouble sleeping
- Fever and chills
- Unexplained weight loss/gain
- Loss of vision
- Double vision
- Eye pain
- Eye drainage
- Hearing loss
- Ear pain
- Ear drainage
- Ringing in ears
- Sinus pain or pressure
- Nasal congestion
- Runny nose
- Sneezing
- Frequent nosebleeds
- Bleeding gums
- Dental problems
- Dentures
- Changing mole
- Weakened urine stream
- Joint pain or swelling
- Skin ulcer or nonhealing sore
- Severe headaches
- Sores in mouth
- Hoarseness
- Swelling in neck
- Chest pain or pressure
- Racing heartbeat
- Palpitations
- Shortness of breath
- Wheezing
- Persistent cough
- Coughing up blood
- Swelling of ankles
- Daytime sleepiness
- Snoring
- Stop breathing during sleep
- Abdominal pain
- Nausea/vomiting
- Heartburn
- Vomiting blood
- Pain with swallowing
- Difficulty swallowing
- Blood in stool
- Black bowel movements
- Constipation
- Diarrhea
- Burning with urination
- Dizziness
- Numbness or tingling
- Slurred speech
- Loss of consciousness
- Seizures
- Paralysis
- Loss of balance
- Generalized weakness
- Excessive thirst
- Excessive urination
- Heat or cold intolerance
- Tremor
- Allergies
- Short of breath when lying flat
- Waking up at night short of breath
- Anxiety
- Depression
- Impaired sexual function
- Lumps or bumps
- Skin rash
- Getting up to urinate at night
- Urinary frequency
- Urinary urgency
- Blood in urine
- Incontinence of urine