Indicate why you are scheduled to see Dr. Flaming: Follow-up, Physical, New Problem, Get Established.

What is the **MAIN** concern/*problem* you would like to focus on today?

_____
_____
_____

Please answer the following concerning this MAIN problem:
What's been this problem's duration in days, weeks, months or years? _____
What helps this problem? _____ What worsens it? _____
Rank the severity of this problem (1-10, 10 being the worst? _____
Where is the problem located on your body? _____
When does it occur? _____
What are YOU doing when this problem occurs (like exertion, resting, eating)?. What other symptoms do you associate with this problem? _____
_____

Describe the quality of the problem or pain (like burning, pressure, sharp, dull)

_____

IF we have time, what other concerns would you like to address? Please describe in detail:

_____
_____
_____

Do you need any medications refilled today? If yes, which ones?

_____
_____
_____

Have you had any tests, X-rays, labs, changes to your medications, consults, hospital or ER visits since (saw you last? If yes, please explain:

_____
_____
_____
_____

List new, non-minor, illnesses/health problems in your immediate family (parents, children, siblings)

_____
_____
_____

Have you ever smoked or used tobacco regularly? _____ If yes, are you still using it? _____
How much tobacco do you typically use in a day? _____ in a week? _____
How old were you when you started using tobacco? _____ If quit, how long ago did you quit tobacco? _____
How many servings of beer, wine or alcohol do you typically drink in a day? _____ in a week? _____
How many servings of caffeine do you typically have each day? _____
At what time do you have your last serving of caffeine? _____
Do you use marijuana or CBD oil? _____ How often? _____
Have you ever used street drugs or IV drugs (shot-up)? _____
Have you been sexually active in the last 12 months? _____
Do you have sex with women, men, or both? _____
Are you single, married, divorced or separated? _____

Please circle any of these symptoms that apply to you.

Constitutional
- Fever/Chills
- Feeling poorly
- Feeling tired
- Recent weight loss/gain
- Night sweats

Eyes
- Eye pain
- Red eyes/discharge
- Vision changes
- Dry eyes
- Itchy eyes

ENT
- Earache
- Sore throat
- Nasal congestion/discharge
- Nosebleeds
- Hoarseness
- Hearing loss

Cardiovascular
- Chest pain
- Irregular heartbeat
- Lower extremity edema
- Leg cramps/pain with exercise
- Slow heart rate
- Fast heart rate

Respiratory
- Shortness of breath
  Shortness of breath during exertion
- Cough
- Wheezing
- Shortness of breath while lying down/at night

Gastrointestinal
- Nausea and/or vomiting
- Abdominal pain
- Diarrhea
- Heartburn
- Constipation
- Trouble swallowing
- Dark or bloody stool

Genitourinary
- Pain with urination
- Frequency/urgency of urination
- Nighttime urination
- Hesitancy
- Incontinence (loss of urine control)
- Blood in urine
- Genital lesion
- Difficulty with menstrual periods (females)
- Erectile dysfunction (males)

Musculoskeletal
- Joint pain
- Joint swelling
- Joint stiffness
- Limb pain/swelling
- Muscle cramps/weakness

Integumentary
- Skin rash
- Itching
- Skin lesions
- Change in mole
- Breast pain/lump
- Wound /unusual growth on skin

Neurological
- Headache
- Dizziness
- Mental changes
- Fainting
- Limb weakness
- Difficulty walking
- Numbness
- Tremor
- Radiating pain

Psychiatric
- Anxiety
- Depression
- Suicidal or homicidal thoughts
- Personality changes/irritability
- Sleep disturbances

Endocrine
- Excessive thirst/urination
- Drooping of eyelid
- Hot or cold intolerance
- Hair loss
- Generalized weakness

Blood/Lymph
- Easy bruising/bleeding
- Swollen glands

Here for a physical?

Please answer the following questions:

Do you see a dentist regularly? _____
Do you see an eye doctor once a year? _____
Are your vaccines up to date? _____
Tetanus? __Flu? ___Pneumonia? ___Hepatitis? ___
Do you eat a healthy diet? _____
Do you feel the need to lose weight? _____
Do you exercise regularly? _____
Do you use Tobacco? ____ Alcohol? ____ Drugs? ____
Are you sexually active? _____
If so, do you use contraception? _____
If so, any problems? _____
Do you use seat belts regularly and drive safely? ___
Do you have smoke detectors? _____
Do you have a carbon monoxide detector? _____
What other health concerns do you have today?
_____