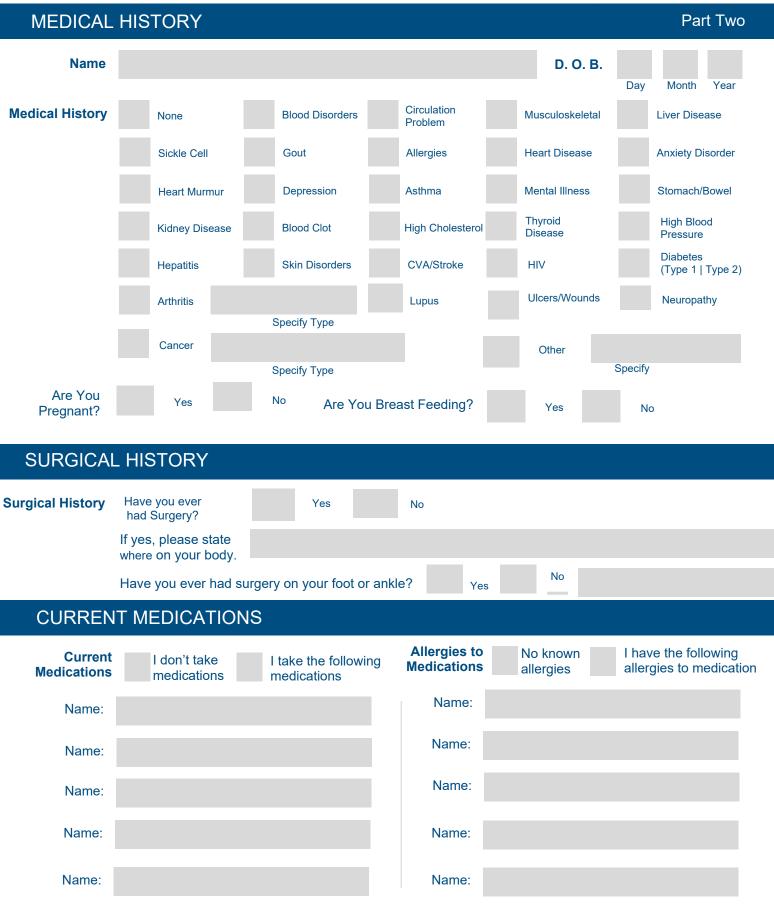


Patient Initial

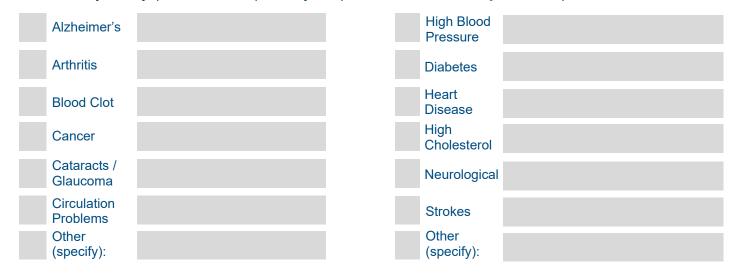






FAMILY HISTORY Part Three

Is there any family (blood relative) history of: (*Please indicate family member*)



REVIEW OF SYSTEMS

Patient Initial

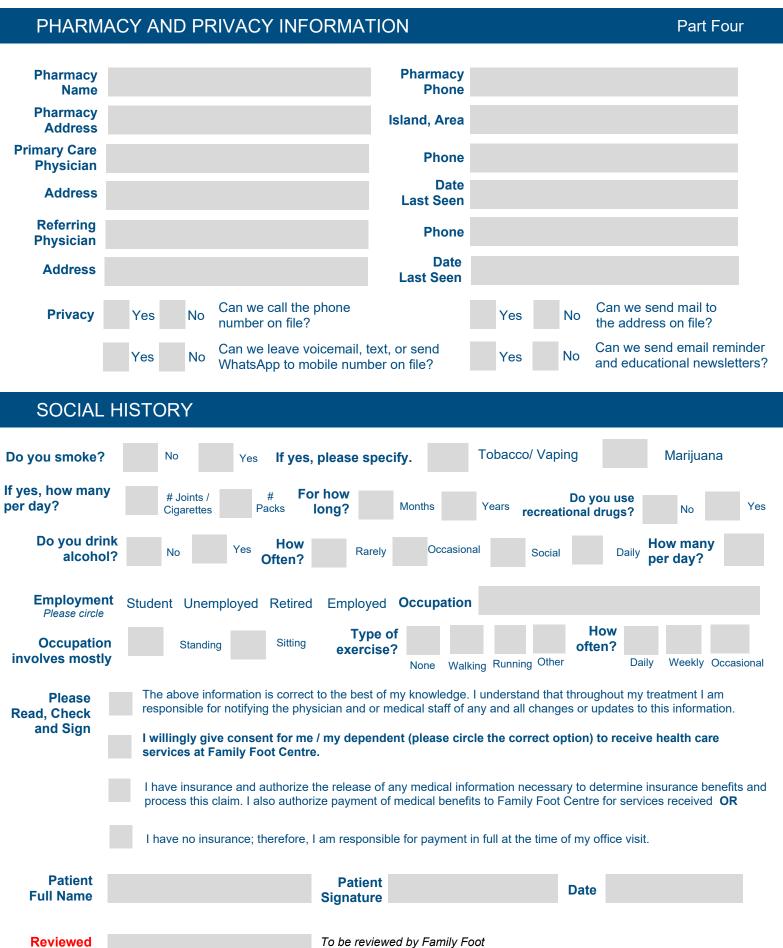
Please check if you are currently experiencing any of these symptoms.

r lease offeon if you are outrefully experientifing arry of these symptoms.					
Cardiovascular (Heart)	None	fever	chest pain / pressure	leg swelling	cold hands / feet
` ,	fainting	palpitations	vascular disease	valve problems	leg pain when walking
Genitourinary (Urine)	None	hesitancy	incontinence	increased urgency	blood in urine
	decreased frequency	excessive urination	kidney disease	kidney stones	
Gastrointestinal	None	111241	va maitim m	constipation	Parella a
(Digestive)		blood in stool	vomiting	Constipation	diarrhea
	trouble swallowing	change in appetite	abdominal pain		
Integumentary (Skin)	None	nail abnormalities	ulcer / wounds	athletes' foot	dry / scaly skin
Hematological (Blood)	None	sickle cell disease	anemia	blood thinners	lower leg ulcers
Neurological (Nerves)	None	weakness	seizures	Numbness / Tingling	headaches
Musculoskeleta (Muscles & bones)	None	joint swelling	muscle weakness	muscle pain	neck pain
	sciatica	joint stiffness	arthritis	back pain	
Respiratory	_				
(Beathing)	None	wheezing	COPD	coughing	snoring
	shortness of breath	emphysema	chest pain		

By



Page 4 of 4 (100% Complete)



Centre Staff.