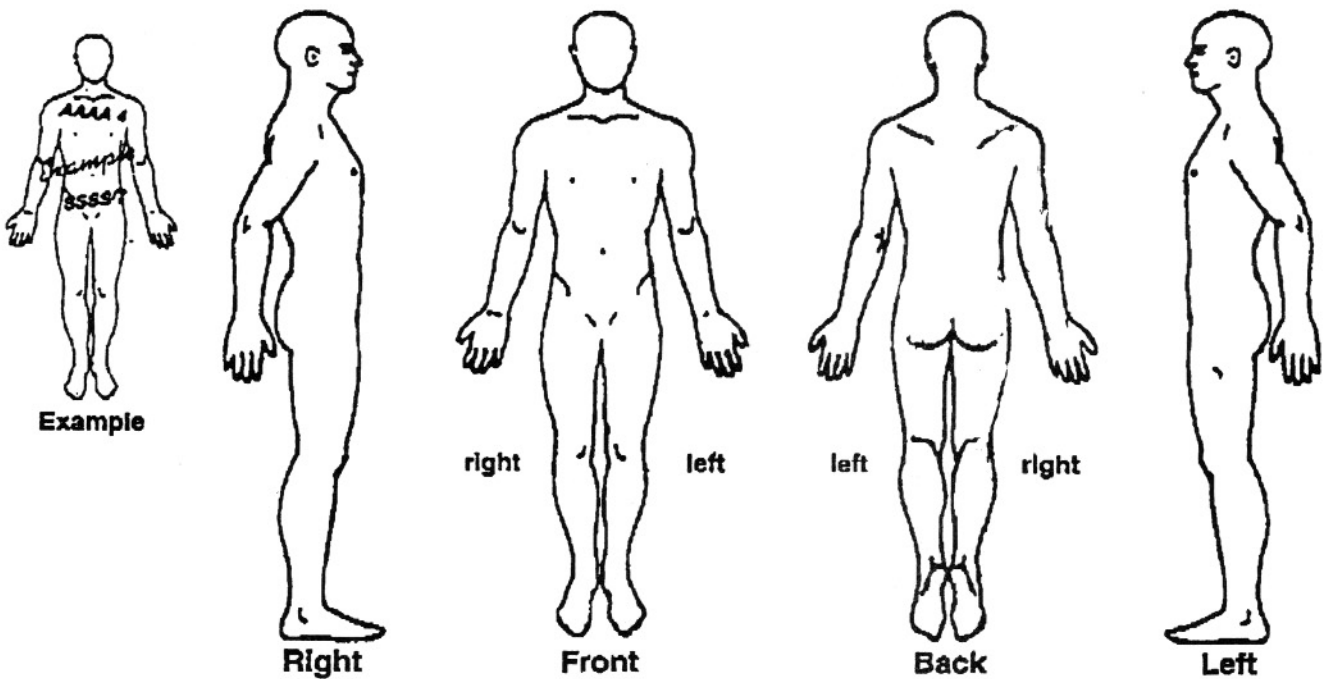


SHOW US WHERE IT HURTS

Please mark **area(s)** of injury or discomfort as shown in the example below. Mark all areas with the appropriate symbols and indicate the degree of pain using a scale from 1 (discomfort) to 10 (extreme pain).

Description → Numbness Pins & Needles Burning Aching Stabbing
 Symbol → NNNN PPPP BBBB AAAA SSSS

○ Circle any area of pain not represented by a symbol



Review of Symptoms

Are you currently, or have you had, problems with:

Constitutional:

	Circle One	
Fever	Yes No	
Weight Loss	Yes No	
Excessive Fatigue	Yes No	
Night Sweats	Yes No	

Eyes

Wear Glasses - Date of Last Exam:	Yes No
-----------------------------------	--------

Infections	Yes No
Injuries	Yes No
Glaucoma	Yes No
Cataracts	Yes No

Ear, Nose, Throat and Mouth

Wear Hearing Aids - Date of Last Exam:	Yes No
--	--------

Hearing Loss	Yes No
Ear Pain	Yes No
Ear Infections	Yes No
Ringing in Ears <i>Circle:</i> Left Right Both	Yes No
Balance Disturbance (e.g. Vertigo, Spinning)	Yes No
Nosebleeds	Yes No
Nasal Congestion	Yes No
Nasal Drainage	Yes No
Amount _____ Color _____	
Inability to Smell	Yes No
Sinus Problems	Yes No

