Hendricks
Endocrinology
& diabetes specialists

Patient Name _____

Please circle yes or no for each question

Cardiology

High blood pressure	yes	no
History of heart attack	yes	no
Chest pain with activity	yes	no
Heart beats fast	yes	no

Constitutional

Fever	yes	no
Chills	yes	no

Dermatology

Rash	yes	no
Itching	yes	no
Dry or sensitive skin	yes	no

Ear/Nose/Throat

Sores in mouth	yes	no
Sinus problems	yes	no
Swelling in throat	yes	no
Hearing loss	yes	no
Ringing in ears	yes	no
Post-nasal drip	yes	no
Hoarseness	yes	no
Swollen lymph nodes	yes	no

Female Reproductive

Heavy Periods	yes	no

Gastroenterology

Nausea	yes	no
Diarrhea	yes	no
Abdominal Pain	yes	no
Vomiting	yes	no

Neurology

History of Stroke	yes	no
Headaches	yes	no
Dizziness	yes	no
Sleep Problems	yes	no

Ophthalmology

Glaucoma	yes	no
Diminished vision	yes	no
Loss of vision	yes	no

Psychology

Depression	yes	no
Anxiety	yes	no

Respiratory

Short of breath with exercise	yes	no
Short of breath when lying down	yes	no
Cough	yes	no
Cough with blood	yes	no

Musculoskeletal

Fracture	yes	no
Falls	yes	no