PAUL DUBRICK, M.D – BRYAN KRUSKOL, D.O. --MEERA ATKINS, M.D.

Name:________________________________Date:__________________________

Are you experiencing any of the following symptoms? Please mark the appropriate box(es).

1. ☐Weight loss ☐Weight gain ☐Fever/Chills
   ☐Fatigue/Weakness ☐No problems

2. ☐Visual changes ☐Blurry vision ☐Double vision
   ☐Eye discharge ☐Cataracts/Glaucoma ☐No problems

3. ☐Mouth problems/ulcers ☐Sore throat ☐Hoarseness
   ☐Neck lumps ☐Sinus pain ☐Nosebleeds
   ☐Headaches ☐Hearing changes ☐Ringing in ears ☐No problems

4. ☐Chest pain ☐Chest pain w/exercise ☐Heart palpitations
   ☐Irregular heartbeat ☐Swelling in legs/feet ☐No problems

5. ☐Shortness of breath ☐Wheezing ☐Coughing
   ☐Blood in sputum ☐No problems

6. ☐Changes in appetite ☐Difficulty swallowing ☐Nausea/Vomiting
   ☐Blood in stools ☐Constipation ☐Diarrhea
   ☐Flatulence ☐Abdominal pain ☐No problems

7. ☐Urinary frequency ☐Burning ☐Blood in urine
   ☐Urine leakage ☐Vaginal discharge ☐Itching ☐No problems

8. ☐Muscle pain ☐Joint swelling ☐Muscle weakness ☐No problems

9. ☐Breast pain ☐Breast lumps ☐Nipple discharge
   ☐Rash around nipple ☐No problems

10. ☐Seizures ☐Dizziness ☐Fainting
    ☐Trouble walking ☐Numbness or tingling ☐No problems

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11. □Mood swings □Rage □Emotional concerns
□Feelings of sadness/crying □Changes in sleep or memory □No problems

12. □Hot flashes □Heat/cold intolerance □Constant fatigue
□No problems

13. □Hair/Skin changes □Skin rash □Acne
□Excessive hair growth □No problems

14. □Bruise easily □Bleed easily □Swollen glands
□No problems

15. □Allergy to medication □Allergy to pets/food/environment
□Allergy to iodine □No problems

Please list any problems previously not mentioned:

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