~~DRAW A LINE THROUGH~~ ALL SYMPTOMS YOU DO NOT HAVE
CIRCLE ALL SYMPTOMS YOU DO HAVE

FATIGUE
FEVER
CHILLS
SWEATS
HEAT OR COLD INTOLERANCE
MUSCLE ACHING
MUSCLE WEAKNESS
SORE THROAT
HEADACHE
SINUS PRESSURE
RUNNY NOSE
EARACHE
ARTHRITIS
INJURY
JOINT SWELLING
BACK PAIN
SHORTNESS OF BREATH
SHORT OF BREATH ON EXERTION
SHORT OF BREATH AS SOON AS LAY DOWN
SHORTNESS OF BREATH THAT WAKES ME UP AT NIGHT
CHEST PAIN
PALPITATIONS OR RACING OR SKIPPING OF THE HEART
CHEST CONGESTION
PLEURISY OR PAIN WHEN YOU TAKE A BREATH
SPUTUM PRODUCTION FROM THE LUNGS
WHEEZING
TROUBLE SWALLOWING WITH FOOD GETTING STUCK IN ESOPHAGUS
ESOPHAGITIS OR BURNING ACID FEELING IN CHEST
REFLUX OF STOMACH ACID INTO THE MOUTH WHEN LAY DOWN OR OTHERWISE
LOSS OF APPETITE
ABDOMINAL OR STOMACH PAIN
BLOATING
NAUSEA
VOMITING
DIARRHEA
CONSTIPATION
BLACK BOWEL MOVEMENTS
YELLOW STOOLS
BRIGHT RED BLOOD ON STOOLS OTR TOILET PAPER
MUCUS ON STOOLS
BURNING ON URINATION
SLOW URINARY STREAM
FREQUENCY OF URINATION
EDEMA OR SWELLING OF LEGS OR HANDS
WEIGHT LOSS OR GAIN

BLACKOUTS
FAINTNESS
DIZZINESS
TINGLING
WEAKNESS OF A LEG OR ARM
LEG CRAMPS
SKIN RASH-ITCHING-LUMP UNDER SKIN-SKIN LESION
BRUISING EASILY
TROUBLE WITH VISION
ANXIETY OR NERVOUSNESS
DEPRESSION
INSOMNIA
HEARING PROBLEMS

PLEASE SIGN AND DATE HERE:

_____ Signature

_____ date

NAME: DATE:

FAMILY HISTORY:

ARE THERE ANY NEW DISEASES THAT HAVE SHOWN THEMSELVES IN YOUR BLOOD RELATIVES SINCE YOUR LAST VISIT WITH DR. GABER?

SOCIAL HISTORY:

HOW MANY A DAY?

EGGS?_____

GLASSES OF MILK?_____

SLICES OF CHEESE?_____

CUPS OF YOGHURT?_____

SCOOPS OF ICE CREAM?_____

GLASSES OF WINE?_____

CANS OF BEER?_____

JIGGERS OF ALCOHOL?_____

CUPS OF COFFEE?_____

CUPS OR GLASSES OF TEA?___

PACKS OF CIGARETTS?_____

CIGARS?_____

MINUTES OF EXERCISE?_____

IF A "PORTION" IS 3 OUNCES OR ABOUT THE SIZE OF A DECK OF CARDS, ON THE AVERAGE, HOW MANY PORTIONS A DAY DO YOU EAT OF:

MEAT?____CHICKEN?____PORK?___FISH?___

DO YOU LIVE: ALONE?__ WITH FAMILY?___

IN A NURSING HOME?___IN AN ASSISTED LIVING FACILITY?_____