

Chief Complaints

Please complete the sections below for each disease or symptom you are currently experiencing. Beginning with section 1, list the diseases or symptoms in the order of importance or severity.

- 1) Symptom or disease: _____
When did any symptoms start? _____
How often do you experience the symptoms? **Circle one:** Daily, every other day, 2-3 times a week, weekly, monthly, other: _____
How long do the episodes last? _____
Have you seen another physician regarding this? Yes ___ No ___
If yes, who and what specialty? _____
What tests did you have done? _____

If so, what treatment was prescribed? _____

List any medications you have taken for these symptoms/this disease: _____

Have you had any side effects or other problems with these medications (ineffective, etc.)? Yes ___ No ___
If so, what medication was it and what was the side effect or result from that medication? (Please list all)

- 2) Symptom or disease: _____
When did any symptoms start? _____
How often do you experience the symptoms? Circle one: Daily, every other day, 2-3 times a week, weekly, monthly, other: _____
How long do the episodes last? _____
Have you seen another physician regarding this? Yes ___ No ___
If yes, who and what specialty? _____
What tests did you have done? _____

If so, what treatment was prescribed? _____

List any medications you have taken for these symptoms/this disease: _____

Have you had any side effects or other problems with these medications (ineffective, etc.)? Yes ___ No ___
If so, what medication was it and what was the side effect or result from that medication? (Please list all)

- 3) Symptom or disease: _____
When did any symptoms start? _____
How often do you experience the symptoms? Circle one: Daily, every other day, 2-3 times a week, weekly, monthly, other: _____
How long do the episodes last? _____
Have you seen another physician regarding this? Yes ___ No ___
If yes, who and what specialty? _____
What tests did you have done? _____

If so, what treatment was prescribed? _____

List any medications you have taken for these symptoms/this disease: _____

Have you had any side effects or other problems with these medications (ineffective, etc.)? Yes ___ No ___
If so, what medication was it and what was the side effect or result from that medication? (Please list all)

4) Symptom or disease: _____
When did any symptoms start? _____
How often do you experience the symptoms? Circle one: Daily, every other day, 2-3 times a week, weekly, monthly, other: _____
How long do the episodes last? _____
Have you seen another physician regarding this? Yes ___ No ___
If yes, who and what specialty? _____
What tests did you have done? _____

If so, what treatment was prescribed? _____

List any medications you have taken for these symptoms/this disease: _____

Have you had any side effects or other problems with these medications (ineffective, etc.)? Yes ___ No ___
If so, what medication was it and what was the side effect or result from that medication? (Please list all)

5) Symptom or disease: _____
When did any symptoms start? _____
How often do you experience the symptoms? Circle one: Daily, every other day, 2-3 times a week, weekly, monthly, other: _____
How long do the episodes last? _____
Have you seen another physician regarding this? Yes ___ No ___
If yes, who and what specialty? _____
What tests did you have done? _____

If so, what treatment was prescribed? _____

List any medications you have taken for these symptoms/this disease: _____

Have you had any side effects or other problems with these medications (ineffective, etc.)? Yes ___ No ___
If so, what medication was it and what was the side effect or result from that medication? (Please list all)

6) Symptom or disease: _____
When did any symptoms start? _____
How often do you experience the symptoms? Circle one: Daily, every other day, 2-3 times a week, weekly, monthly, other: _____
How long do the episodes last? _____
Have you seen another physician regarding this? Yes ___ No ___
If yes, who and what specialty? _____
What tests did you have done? _____

If so, what treatment was prescribed? _____

List any medications you have taken for these symptoms/this disease: _____

Have you had any side effects or other problems with these medications (ineffective, etc.)? Yes ___ No ___
If so, what medication was it and what was the side effect or result from that medication? (Please list all)

