

NAME: _____

DOB: _____

PLEASE COMPLETE BUBBLE SHEET THOROUGHLY

Urology

Frequent urination Yes No
 Urgent need to urinate Yes No
 Pain with urination Yes No
 Nighttime urination Yes No
 Difficulty starting urinary stream Yes No
 Leakage or dribbling Yes No
 Reduced flow Yes No
 Blood in urine Yes No
 Straining to urinate Yes No
 Pelvic pain Yes No
 Sexual difficulty Yes No
 Female-infertility Yes No
 Female-irregular periods Yes No
 Female- vaginal discharge Yes No
 Other: _____

Male Reproductive

Difficulty with erection Yes No
 Difficulty with ejaculation Yes No
 Diminished sexual drive Yes No
 Other: _____

Cardiology

swelling of feet, ankles, or hands Yes No
 shortness of breath Yes No
 chest pain at rest Yes No
 Chest pain with exertion Yes No
 Dizziness Yes No
 Irregular heartbeat Yes No
 Palpitations Yes No
 Other: _____

Dermatology

Scars Yes No
 Rash Yes No
 Dry or Sensitive Skin Yes No
 Hives Yes No
 Acne Yes No
 Skin cancer Yes No
 Other: _____

Endocrinology

Fatigue Yes No
 Excessive Thirst Yes No
 Excessive Urination Yes No
 Cold Intolerance Yes No
 Hot flashes Yes No
 Weight Loss Yes No
 Other: _____

ENT

difficulty swallowing Yes No
 Sore throat Yes No
 Cough Yes No
 Sinus Problems Yes No
 hearing loss/hard of hearing Yes No
 nose bleeds Yes No
 Tinnitus (ringing in ear) Yes No
 Other: _____

Gastroenterology

black/tarry stools Yes No
 diarrhea Yes No
 abdominal pain Yes No
 nausea/vomiting Yes No
 Heartburn / indigestion Yes No
 blood in stool Yes No
 Constipation Yes No
 Other: _____

General

fever Yes No
 Chills Yes No
 fatigue Yes No
 weakness Yes No
 weight loss Yes No
 weight gain Yes No
 Other: _____

Hematologic/Lymphatic

excessive bleeding w/dental work Yes No
 easy bruising Yes No
 swollen glands Yes No
 loss of appetite Yes No
 Other: _____

Musculoskeletal

fracture Yes No
 back pain Yes No
 Bone pain Yes No
 Muscle weakness Yes No
 Joint swelling, stiffness, pain Yes No
 Other: _____

Neurology

Insomnia Yes No
 Dizziness Yes No
 Weakness Yes No
 Headache Yes No
 Numbness Yes No
 Seizures/Convulsions Yes No
 Leg weakness Yes No
 Other: _____

Ophthalmology

blurring of vision Yes No
 eye drainage Yes No
 eye irritation, pain Yes No
 loss of vision Yes No
 Spots in vision Yes No
 Other: _____

Respiratory

Shortness of breath Yes No
 Need for home oxygen Yes No
 Chest pain Yes No
 Cough Yes No
 Chronic/Frequent cough Yes No
 Difficulty breathing at rest Yes No
 Difficulty breath on exertion Yes No
 Other: _____