

Patients Name \_\_\_\_\_ Date \_\_\_\_\_

Are you claustrophobic?  Yes  No History of kidney disease?  Yes  No

Are you pregnant or think you may be ?  Yes  No

Main reason for today's visit: \_\_\_\_\_

Please put a check by the symptoms you are currently experiencing:

- |   |   |
|---|---|
| <input type="checkbox"/> Fatigue                  | <input type="checkbox"/> Abdominal Pain           |
| <input type="checkbox"/> Fever                    | <input type="checkbox"/> Constipation             |
| <input type="checkbox"/> Weight Gain >10 lbs.     | <input type="checkbox"/> Diarrhea                 |
| <input type="checkbox"/> Weight Loss > 10 lbs.    | <input type="checkbox"/> Nausea                   |
| <input type="checkbox"/> Bruising                 | <input type="checkbox"/> Backache                 |
| <input type="checkbox"/> Hair Loss                | <input type="checkbox"/> Joint Pain               |
| <input type="checkbox"/> Itching                  | <input type="checkbox"/> Muscle Cramps            |
| <input type="checkbox"/> Rash                     | <input type="checkbox"/> Decreased Memory         |
| <input type="checkbox"/> Blurred Vision           | <input type="checkbox"/> Dizziness                |
| <input type="checkbox"/> Double Vision            | <input type="checkbox"/> Fainting                 |
| <input type="checkbox"/> Visual Loss              | <input type="checkbox"/> Headaches                |
| <input type="checkbox"/> Decreased Hearing        | <input type="checkbox"/> Seizures                 |
| <input type="checkbox"/> Tinnitus                 | <input type="checkbox"/> Vertigo                  |
| <input type="checkbox"/> Sinus Pain               | <input type="checkbox"/> Weakness in Extremities  |
| <input type="checkbox"/> Hoarseness               | <input type="checkbox"/> Anxiety                  |
| <input type="checkbox"/> Cough                    | <input type="checkbox"/> Change in Sleep Pattern  |
| <input type="checkbox"/> Difficulty Breathing     | <input type="checkbox"/> Depression               |
| <input type="checkbox"/> Sputum Production        | <input type="checkbox"/> Inability to Concentrate |
| <input type="checkbox"/> Chest Pain               | <input type="checkbox"/> Abnormal Bleeding        |
| <input type="checkbox"/> Irregular Heart Beat     | <input type="checkbox"/> Anemia                   |
| <input type="checkbox"/> Leg Pain and/or Swelling | <input type="checkbox"/> Easy Bruising            |
|   | <input type="checkbox"/> None of the above        |