**PATIENT SYMPTOMS UPDATE**

***Dr. Eric Tondera, NP-C, DC***

Patient Name: _____ Today's Date: _____ DOB: _____ AGE: _____

Best Daytime #: _____ Best Evening #: _____ e-mail: _____

Height: _____ Weight: _____ ( ) OK to leave message? Y / N

| **General Health Questions: I have had these symptoms/conditions for: 0-3 months 3-6 months OVER 6 months** | |
|---|---|
| ( ) Chronic Pain ( ) Numbness ( ) Tingling ( ) Pins & Needles | Y / N |
| ( ) Limb Pain in Arms or Legs ( ) Lower Extremity Swelling and Edema | Y / N |
| ( ) Tired ( ) Weakness ( ) Fatigue | Y / N |
| ( ) Shortness of Breath ( ) Chest Pain ( ) Palpitations ( ) Rapid or Irregular Heart Beat ( ) Abnormal EKG ( ) PVC's | Y / N |
| ( ) Asthma ( ) Bronchitis ( ) COPD ( ) Exercise Intolerance ( ) Exercise Induced Bronchospasm | Y / N |
| ( ) High Blood Pressure ( ) High Cholesterol ( ) Circulatory Problems ( ) Peripheral Artery Disease | Y / N |
| ( ) Coronary Artery Disease ( ) Hypertensive Heart Disease ( ) History of Cardiac Arrest | Y / N |
| ( ) Light Headed/Fainting ( )Dizziness (worse when rising from a seated or lying position)( ) Night Vision Problems | Y / N |
| ( ) Gastrointestinal Problems ( ) Difficulty digesting food ( ) Excessive Sweating | Y / N |
| ( ) Hypoglycemia ( ) Type II Diabetes ( ) Long Term Drug Therapy | Y / N |

| **Quality of Sleep: I have had these symptoms/conditions for: 0-3 months 3-6 months OVER 6 months** | |
|---|---|
| Do you stop breathing, choke, or gasp for air during sleep? | Y / N |
| Do your legs kick at night and interfere with your sleep? | Y / N |
| Have you been told that you snore loudly? | Y / N |
| Do you have difficulty falling and staying asleep? | Y / N |
| How many hours of restful sleep do you get most nights? | _____ |
| Do you currently use a CPAP machine? For how long? _____ | Y / N |

***How likely are you to Doze off or Fall Asleep in the following situations? (0=Never,1=Slight,2=Moderate,3=High)***

| | | | |
|---|---|---|---|
| Sitting and Reading | 0 1 2 3 | Lying Down to Rest in the Afternoon | 0 1 2 3 |
| Watching Television | 0 1 2 3 | While Having a Relaxed Conversation | 0 1 2 3 |
| Sitting Quietly After Lunch | 0 1 2 3 | In a Car While Stopped at a Traffic Signal | 0 1 2 3 |
| As a Passenger in a Car for One Hour | 0 1 2 3 | Sitting Inactive in a Seminar, Theater or Meeting | 0 1 2 3 |

| **Bladder Function: I have had these symptoms/conditions for: 0-3 months 3-6 months OVER 6 months** | |
|---|---|
| Do you lose urine while coughing, sneezing, laughing, lifting, jumping or running? | Y / N |
| Do you use protective undergarments because you cannot hold your urine? | Y / N |
| Do you wet your clothing because you cannot make it to the bathroom in time? | Y / N |
| Do you have to hurry to empty your bladder when full? | Y / N |
| How often do you urinate during the day? (_____) times. Wake to urinate during the night? (_____) times | |

**Major Accidents/Traumas: _____**

**Major Surgeries: _____**

**Medications: _____ (if longer than 6 months)**

***Your doctor is affiliated with Texas Medical Alliance, a diagnostic services provider. Your physician is constantly striving to provide the most comprehensive patient care for their patient population. Through our affiliation with Texas Medical Alliance we are able to provide patients with more "In Network" options, including specialized testing provided here at this location. Upon Medical review and under the directions of your physician, you may be contacted by the Medical Scheduling Department of Texas Medical Alliance to schedule further testing.***

Patient Signature: _____ Date: _____