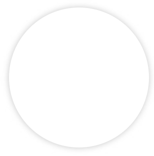

Titus Care

719 Jadwin Avenue Suite 4 Richland WA 99352

509-827-1253

Primary Health Concerns

Please list your primary health concerns in the order of importance.

Concern Ex:Fever	Since Ex:Last 2 Months	Frequency Ex:Daily	Severity Ex:High

Life-style

Import From Previous Consult

Smoking (#/Day)

Alcohol (#/Week)

Coffee (#/Day)

Tea (#/Day)

Soda (#/Day)

Water (#/Day)

Sleep (Hours/Day)

Meals (#/Day)

Stress Level

Energy Level

Exercise (Hours/week)

Relaxation/Yoga/Tai Chi (#/Week)

Breakfast Timing

Breakfast Items

Lunch Timing

Lunch Items

Dinner Timing

Dinner Items

Snacks Timing

Snacks Items

Notes

Review of Systems V2

Please review the following symptoms

Set None to All

Full Body ☐ **None**

Weight Change ◯ Yes ◯ No ☐ Past

Fever/Chills ◯ Yes ◯ No ☐ Past

Weakness ◯ Yes ◯ No ☐ Past

Fatigue ◯ Yes ◯ No ☐ Past

Sweats/Night Sweats ◯ Yes ◯ No ☐ Past

Change in appetite ◯ Yes ◯ No ☐ Past

Bleed/bruise easily ◯ Yes ◯ No ☐ Past

Change in Sleep ◯ Yes ◯ No ☐ Past

Hot Flashes ◯ Yes ◯ No ☐ Past

Notes

Eyes ☐ **None**

Vision/Glasses ◯ Yes ◯ No ☐ Past

Blurring ◯ Yes ◯ No ☐ Past

Pain ◯ Yes ◯ No ☐ Past

Discharge	○ Yes ○ No ☐ Past	Dryness	○ Yes ○ No ☐ Past	Glaucoma	○ Yes ○ No ☐ Past
Cataracts	○ Yes ○ No ☐ Past	Styes	○ Yes ○ No ☐ Past	Dark under Eyelid	○ Yes ○ No ☐ Past

Notes

Ears, Nose, Mouth, Throat ☐ **None**

Tinnitus (ringing)	○ Yes ○ No ☐ Past	Diminished Hearing	○ Yes ○ No ☐ Past	Postnasal Drip	○ Yes ○ No ☐ Past
Bleeding	○ Yes ○ No ☐ Past	Obstruction	○ Yes ○ No ☐ Past	Mouth Sores	○ Yes ○ No ☐ Past
Teeth Problems	○ Yes ○ No ☐ Past	Hoarseness	○ Yes ○ No ☐ Past	Taste Problem	○ Yes ○ No ☐ Past
Nasal Polyps	○ Yes ○ No ☐ Past	Sore Throat	○ Yes ○ No ☐ Past	Gum disease	○ Yes ○ No ☐ Past

Notes

Neck ☐ **None**

Stiffness	○ Yes ○ No ☐ Past	Swollen Glands	○ Yes ○ No ☐ Past

Notes

Cardiovascular ☐ **None**

Palpitation	○ Yes ○ No ☐ Past	Pain	○ Yes ○ No ☐ Past	Chest Pain	○ Yes ○ No ☐ Past
Edema (Swelling)	○ Yes ○ No ☐ Past	Hypertension	○ Yes ○ No ☐ Past	Low BP	○ Yes ○ No ☐ Past
Arrhythmias	○ Yes ○ No ☐ Past	Rheumatic Fever	○ Yes ○ No ☐ Past	Heart palpitations	○ Yes ○ No ☐ Past

Notes

Respiratory ☐ **None**

Dyspnea (Breathlessness) ○ Yes ○ No ☐ Past
Wheezing ○ Yes ○ No ☐ Past
Cough ○ Yes ○ No ☐ Past
Sputum (cough) ○ Yes ○ No ☐ Past
Shortness of breath ○ Yes ○ No ☐ Past
TB ○ Yes ○ No ☐ Past
Bronchitis ○ Yes ○ No ☐ Past
Pneumonia ○ Yes ○ No ☐ Past
Asthma ○ Yes ○ No ☐ Past

Notes

Gastrointestinal ☐ **None**

Appetite ○ Yes ○ No ☐ Past
Pain ○ Yes ○ No ☐ Past
Indigestion ○ Yes ○ No ☐ Past
Difficulty swallowing ○ Yes ○ No ☐ Past
Jaundice ○ Yes ○ No ☐ Past
Blood in Stool ○ Yes ○ No ☐ Past
Constipation ○ Yes ○ No ☐ Past
Anal Discomfort ○ Yes ○ No ☐ Past
Nausea ○ Yes ○ No ☐ Past
Vomiting ○ Yes ○ No ☐ Past
Diarrhea ○ Yes ○ No ☐ Past
Heartburn ○ Yes ○ No ☐ Past
Bloating ○ Yes ○ No ☐ Past
Pancreatitis ○ Yes ○ No ☐ Past
Hemorrhoids ○ Yes ○ No ☐ Past
Gall Bladder Disease ○ Yes ○ No ☐ Past
Liver Disease ○ Yes ○ No ☐ Past
Infrequent/Inconsistent bowels ○ Yes ○ No ☐ Past

Notes

Genitourinary (Genital & Urinary) ☐ **None**

Painful urination ○ Yes ○ No ☐ Past
Night urinations ○ Yes ○ No ☐ Past
Blood in urine ○ Yes ○ No ☐ Past
Frequent urinations ○ Yes ○ No ☐ Past
Incontinence ○ Yes ○ No ☐ Past

Notes

Musculoskeletal ☐ **None**

Trauma ○ Yes ○ No ☐ Past
Swelling ○ Yes ○ No ☐ Past
Pain ○ Yes ○ No ☐ Past

Arthritis	○ Yes ○ No ☐ Past	Tremors	○ Yes ○ No ☐ Past	Stiffness	○ Yes ○ No ☐ Past

Notes

Neurological ☐ **None**

Fainting	○ Yes ○ No ☐ Past	Convulsions	○ Yes ○ No ☐ Past	Sensations	○ Yes ○ No ☐ Past
Coordination	○ Yes ○ No ☐ Past	Speech	○ Yes ○ No ☐ Past	Carpal tunnel	○ Yes ○ No ☐ Past
Seizures	○ Yes ○ No ☐ Past	Sciatica	○ Yes ○ No ☐ Past	Paralysis	○ Yes ○ No ☐ Past

Notes

Psychiatric ☐ **None**

Memory Loss	○ Yes ○ No ☐ Past	Mood swings	○ Yes ○ No ☐ Past	Sleep Pattern	○ Yes ○ No ☐ Past
Anxiety	○ Yes ○ No ☐ Past	Depression	○ Yes ○ No ☐ Past	Phobia	○ Yes ○ No ☐ Past
Drug/Alcohol Abuse	○ Yes ○ No ☐ Past	Suicidal	○ Yes ○ No ☐ Past	Anger/irritability	○ Yes ○ No ☐ Past

Notes

Endocrine ☐ **None**

Goiter	○ Yes ○ No ☐ Past	Tremor	○ Yes ○ No ☐ Past	Hormone Therapy	○ Yes ○ No ☐ Past
Heat/Cold Intolerance	○ Yes ○ No ☐ Past				

Notes

Hematologic/Lymphatic ☐ **None**

Anemia	○ Yes ○ No ☐ Past	Bleeding Tendency	○ Yes ○ No ☐ Past	Transfusion	○ Yes ○ No ☐ Past

Enlarged lymph nodes ○ Yes ○ No ☐ Past

Notes

Allergic/Immunologic ☐ **None**

Hives ○ Yes ○ No ☐ Past | Hay Fever ○ Yes ○ No ☐ Past | Seasonal Allergies ○ Yes ○ No ☐ Past

Notes

Head ☐ **None**

Headache ○ Yes ○ No ☐ Past | Trauma/Head Injury ○ Yes ○ No ☐ Past | Migraine ○ Yes ○ No ☐ Past

Hair Loss ○ Yes ○ No ☐ Past | Dandruff ○ Yes ○ No ☐ Past | Oily ○ Yes ○ No ☐ Past

Notes

Skin ☐ **None**

Itching ○ Yes ○ No ☐ Past | Rash ○ Yes ○ No ☐ Past | Psoriasis/eczema ○ Yes ○ No ☐ Past

Cancer ○ Yes ○ No ☐ Past | Color Change ○ Yes ○ No ☐ Past | Lump ○ Yes ○ No ☐ Past

Wart/Moles ○ Yes ○ No ☐ Past | Dry skin ○ Yes ○ No ☐ Past | Skin lesions ○ Yes ○ No ☐ Past

Notes

Male ☐ **None**

Testicular pain/swelling ○ Yes ○ No ☐ Past | Hernia ○ Yes ○ No ☐ Past | Prostate Disease/Symptoms ○ Yes ○ No ☐ Past

Discharge ○ Yes ○ No ☐ Past

Notes

Female ☐ **None**

Breast Masses	○ Yes ○ No ☐ Past	Breast Pain	○ Yes ○ No ☐ Past	Nipple Discharge	○ Yes ○ No ☐ Past
Menstrual Cramping	○ Yes ○ No ☐ Past	Any abnormal paps	○ Yes ○ No ☐ Past	Dry vagina	○ Yes ○ No ☐ Past
Dexa Scan	○ Yes ○ No ☐ Past	Heavy menstrual bleeding	○ Yes ○ No ☐ Past	Menstrual Pain	○ Yes ○ No ☐ Past
Vaginitis	○ Yes ○ No ☐ Past	Pain w/intercourse	○ Yes ○ No ☐ Past	Vaginal discharge	○ Yes ○ No ☐ Past
Irregular periods	○ Yes ○ No ☐ Past	Uterine fibroids	○ Yes ○ No ☐ Past	Ovarian cysts	○ Yes ○ No ☐ Past

Notes

STI ☐ **None**

Syphilis	○ Yes ○ No ☐ Past	Gonorrhea	○ Yes ○ No ☐ Past	Sores/Discharge	○ Yes ○ No ☐ Past
Chlamydia	○ Yes ○ No ☐ Past	Herpes	○ Yes ○ No ☐ Past		

Notes

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