VIKING
ALTERNATIVE MEDICINE

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Name : **DOB:** **Gender:** **Race:**

Health Assessment

History of Past/Present Illness :
(Including, but not limited to obesity / diabetes / thyroid / cancer)

Vital Signs
BP:
Pulse:
02:
Temp:
Height:
Weight:
BMI:

Past Medical History:
- ☐ CAD ☐ COPD
- ☐ MI ☐ Asthma
- ☐ CHF ☐ DM
- ☐ PAD ☐ CDK
- ☐ HTN ☐ Thyroid

Review of Symptoms:

Constitutional:
- ☐ Appetite change
- ☐ Activity change
- ☐ Fatigue
- ☐ Fever
- ☐ Chills
- ☐ Weight change

Eyes:
- ☐ Pain
- ☐ Redness
- ☐ Discharge
- ☐ Swelling
- ☐ Photophobia
- ☐ Visual disturbance

Ears:
- ☐ Pain
- ☐ Discharge
- ☐ Tinnitus
- ☐ Hearing loss

Nose:
- ☐ Congestion
- ☐ Sinus pressure
- ☐ Sinus pain
- ☐ Epistaxis

Throat:
- ☐ Pharyngitis
- ☐ Voice change

Endocrine:
- ☐ Heat intolerance
- ☐ Cold intolerance
- ☐ Polyuria
- ☐ Polyphagia
- ☐ Polydipsia

Respiratory:
- ☐ Cough
- ☐ Dyspnea
- ☐ Wheezing
- ☐ Apnea
- ☐ Choking
- ☐ Chest tightness

Cardio:
- ☐ Chest pain
- ☐ Leg swelling
- ☐ Palpitations

GI:
- ☐ Pain
- ☐ Distention
- ☐ Constipation
- ☐ Diarrhea
- ☐ Nausea
- ☐ Vomiting
- ☐ Rectal bleeding
- ☐ Blood in stool

GU:
- ☐ Difficulty urinating
- ☐ Dyspareunia
- ☐ Dysuria
- ☐ Enuresis
- ☐ Flank pain
- ☐ Frequency
- ☐ Genital sore
- ☐ Hematuria
- ☐ Menstrual problem
- ☐ Pelvic pain
- ☐ Urgency
- ☐ Vaginal pain
- ☐ Vaginal discharge
- ☐ Vaginal bleeding

Musculoskeletal:
- ☐ Arthralgias
- ☐ Back pain
- ☐ Joint swelling
- ☐ Myalgias
- ☐ Neck pain
- ☐ Neck stiffness
- ☐ Gait problem

Skin:
- ☐ Rash
- ☐ Wound

Neuro:
- ☐ Headaches
- ☐ Dizziness
- ☐ Light-headed
- ☐ Numbness
- ☐ Seizures
- ☐ Speech issues
- ☐ Syncope
- ☐ Tremors
- ☐ Weakness

Psych:
- ☐ Agitation
- ☐ Behavior issues
- ☐ Confusion
- ☐ Depression
- ☐ Anxious
- ☐ Suicidal
- ☐ Homicidal
- ☐ Insomnia
- ☐ Hypersomnia
- ☐ Self Injury
- ☐ Hallucinations
- ☐ Difficulty concentrating

Physical Exam:
(note abnormal findings)

General/Psych:

HEENT:

Neck:

Cardiovascular:

Pulmonary:

Abdominal:

GU:

Musculoskeletal:

Neuro:

Skin:

Allergies:

Medications:

Assessment:

REVIEWING PHYSICAN: _____ DATE: _____

PHYSICIAN SIGNATURE: _____