

Contact Information			
Name	Last	First	
Address			
Billing Address (if different)			
Email Address			
Contact Phone	Home ()	Work ()	Mobile ()
Identification	Social Security No.	Driver's License (State and No.)	
Demographic			
Date of Birth	Birth Date	Age	
Ethnic Race	<input type="radio"/> Caucasian	<input type="radio"/> Black	<input type="radio"/> Asian <input type="radio"/> Hispanic <input type="radio"/> Other
Marital Status	<input type="radio"/> Single	<input type="radio"/> Married	<input type="radio"/> Separated <input type="radio"/> Divorced <input type="radio"/> Widowed
Gender	<input type="radio"/> Female		<input type="radio"/> Male
Height and Weight	Height	Ft. In.	Current Weight
Number of Children and Ages	No. of Children:	Ages: / / / / /	
Employment Information			
Are you employed?	<input type="radio"/> No	<input type="radio"/> Yes, occupation: _____	
Employer Name			
Employer Address and Phone			
Insurance Information			
Insurance Company Name	Primary Insurance	Secondary Insurance	
Insurance Address and Phone			
Member ID			
Group Number			
Effective Date			
Plan Name/Type			
Relationship to Insured			
If your relationship to the Insured is not "Self," please complete the section below:			
Insured Person's Name	Primary Insurance	Secondary Insurance	
Insured Person's Social Security			
Insured's Group Number			
Subscriber ID			

Primary Care Physician		
Physician Name		
Physician Address and Phone		
Referral Information		
How did you hear of us?	<input type="radio"/> Physician <input type="radio"/> Family/Friend <input type="radio"/> Internet <input type="radio"/> Radio/TV <input type="radio"/> Other	
Patient Information Seminar	<input type="radio"/> Attended Live Seminar	<input type="radio"/> Viewed Online Seminar Entirely
Referring Physician Name		
Physician Address and Phone		
Who can we thank for this referral? Please indicate name and address.		
Weight Loss History		
Main reason for wanting treatment for weight loss?		
From what age have you been obese? When did you begin to have issues with your weight?		
Have you attempted to diet? Please indicate number of weight loss methods tried to date.		
Lifetime Experiences	Lifetime Maximum Weight:	Highest Weight Loss from Single Diet:
Medically-Supervised Diet History in the Past 6 Years		
1. Name of Program:	Start and End Dates/Duration	Supervising Physician Name and Phone
Weight Lost:	Weight Regained:	Medication:
2. Name of Program:	Start and End Dates	Supervising Physician Name and Phone
Weight Lost:	Weight Regained:	Medication:
3. Name of Program:	Start and End Dates	Supervising Physician Name and Phone
Weight Lost:	Weight Regained:	Medication:
4. Name of Program:	Start and End Dates	Supervising Physician Name and Phone
Weight Lost:	Weight Regained:	Medication:
5. Name of Program:	Start and End Dates	Supervising Physician Name and Phone
Weight Lost:	Weight Regained:	Medication:

Commonly Prescribed Weight Loss Medication

Have you ever taken prescribed medication for weight loss?	<input type="radio"/> No	<input type="radio"/> If yes, please check all ever taken:
<input type="checkbox"/> Amphetamines	<input type="checkbox"/> Diethylpropin	<input type="checkbox"/> Pondamine/Fenfluramine
<input type="checkbox"/> Benzphetamine/Didrex	<input type="checkbox"/> Ionamin/Adipex (Phentermine)	<input type="checkbox"/> Prozac (Fluoxetine)
<input type="checkbox"/> Bontril/Phendimetrazine	<input type="checkbox"/> Meridia (Sibutramine)	<input type="checkbox"/> Redux (Dexfenfluramine)
<input type="checkbox"/> Dexedrine/Dextroamphetamine/Liquadd	<input type="checkbox"/> Phen-Fen	<input type="checkbox"/> Other, _____

Non-Medically Supervised Diet History in the Past 6 Years

Which diet programs/methods have you tried in the past 6 years? Weight Watchers, Jenny Craig, Overeaters Anonymous, Nutri-System, Atkins, High Protein, Low Carbohydrate, Low Fat, Calorie Counting, Hypnosis, Health Spa diets, Optifast, Slim Fast, etc. Please describe your diet experiences below.

Name of Diet:	Start and End Dates/Duration:	Weight Lost:	Weight Regained:	Medication:

Common Over-the-Counter Weight Loss Drugs

Have you ever taken over-the-counter drugs for weight loss?	<input type="radio"/> No	<input type="radio"/> If yes, please check all ever taken:
<input type="checkbox"/> Alli Hoodia	<input type="checkbox"/> Fastin	<input type="checkbox"/> Plegine
<input type="checkbox"/> Accutrim	<input type="checkbox"/> Mazanor	<input type="checkbox"/> Sanorex
<input type="checkbox"/> Anorex	<input type="checkbox"/> Obalan	<input type="checkbox"/> Tepanol
<input type="checkbox"/> Dexatrim (Phenylpropanolamine)	<input type="checkbox"/> Phendinet/Pentrol	<input type="checkbox"/> Other, _____

Exercise Regimen

Do you find exercising difficult?	<input type="radio"/> No	<input type="radio"/> Yes, please explain: _____
How often do you exercise?	<input type="radio"/> 2 or more days a week	<input type="radio"/> Fewer than 2 days a week
Do you exercise with a trainer or follow a specific exercise regimen?	<input type="radio"/> No	<input type="radio"/> Yes, please explain: _____
How do you exercise?	<input type="radio"/> Walk <input type="radio"/> Jog/Run <input type="radio"/> Swim <input type="radio"/> Weights <input type="radio"/> Other	

Medical History: Operations and Surgical Procedures

Procedure:	Date of Service:	Type of Anesthesia:	Problems, if any:
1.			
2.			
3.			
4.			
5.			

Medical History: Current Illnesses and Health Issues

Illness and Issues:	Explain:
1.	
2.	
3.	
4.	
5.	
6.	

Medical History: Current Medications and Allergies

What medications are you currently taking? Please list below.

MEDICINE	DOSAGE	FREQUENCY
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

Have you ever taken Phen-Fen? Yes No For how long?

Are you allergic to any medications? (If yes, list medications) Yes No

MEDICATION	REACTION
1.	
2.	
3.	

Do you have allergies, including foods? (If yes, list allergies) Yes No

ALLERGIES	REACTION
1.	
2.	
3.	

Check if you have any of these specific allergies. Hay Fever Soybean Egg Eczema Iodine

Social History: Eating Habits			
Do you eat breakfast?	<input type="radio"/> 3 or more days a week	<input type="radio"/> 1 or 2 days a week	
Do you snack at night?	<input type="radio"/> 3 or more days a week	<input type="radio"/> 1 or 2 days a week	
Do you snack during the day?	<input type="radio"/> 3 or more days a week	<input type="radio"/> 1 or 2 days a week	
Do you drink soda or very sugary liquids?	<input type="radio"/> 3 or more days a week	<input type="radio"/> 1 or 2 days a week	
Do you eat desserts?	<input type="radio"/> 3 or more days a week	<input type="radio"/> 1 or 2 days a week	
Do you eat fried foods?	<input type="radio"/> 3 or more days a week	<input type="radio"/> 1 or 2 days a week	
Do you binge eat? (Binge eating is when you eat a lot more than you feel you should eat.)	<input type="radio"/> 3 or more days a week	<input type="radio"/> 1 or 2 days a week	
How large are your meals compared to normal weight people eating the same meal?	<input type="radio"/> Smaller	<input type="radio"/> Similar	<input type="radio"/> Larger <input type="radio"/> Don't Know
Social History: Sleeping Habits			
How often do you have restless sleep or frequent awakening?	<input type="radio"/> 2 or more days a week	<input type="radio"/> Fewer than 2 days a week	
How often do you have night sweats?	<input type="radio"/> 2 or more days a week	<input type="radio"/> Fewer than 2 days a week	
How often do you snore?	<input type="radio"/> 2 or more days a week	<input type="radio"/> Fewer than 2 days a week	
How often do you have daytime sleepiness?	<input type="radio"/> 2 or more days a week	<input type="radio"/> Fewer than 2 days a week	
How often do you have morning headaches?	<input type="radio"/> 2 or more days a week	<input type="radio"/> Fewer than 2 days a week	
Do you wake at night with a snort or gasp?	<input type="radio"/> No	<input type="radio"/> Yes, please explain and indicate frequency:	
In the past year, has anyone told you that you held your breath for a long time while asleep?	<input type="radio"/> No	<input type="radio"/> Yes, please explain and indicate frequency:	
Social History: Personal Habits			
Do you smoke?	<input type="radio"/> No	<input type="radio"/> Yes, cigarettes _____ or _____ packs per day	
Do you drink alcohol?	<input type="radio"/> No	<input type="radio"/> Less than 2 per month	<input type="radio"/> Once a week <input type="radio"/> Daily
Have you ever been in an alcohol rehabilitation program?	<input type="radio"/> No	<input type="radio"/> Yes, please specify:	
Do you use recreational drugs?	<input type="radio"/> No	<input type="radio"/> Yes, please explain and indicate frequency:	
Do you exercise regularly?	<input type="radio"/> No	<input type="radio"/> Yes, please explain and indicate frequency:	

Family History			
Counting yourself, your full brothers and sisters, and your parents, how many people are in your immediate family?			No. _____
How many people in your immediate family (yourself included) were at one time or another 75 lbs. or more overweight?			No. _____
Has any blood relative ever had a problem with anesthetics (e.g. malignant hyperthermia)			<input type="radio"/> No <input type="radio"/> Yes
Does anyone in your family have diabetes?	<input type="radio"/> No <input type="radio"/> Yes	Relation:	
Does anyone in your family have high blood pressure?	<input type="radio"/> No <input type="radio"/> Yes	Relation:	
Does anyone in your family have heart disease?	<input type="radio"/> No <input type="radio"/> Yes	Relation:	
Does anyone in your family have gallstones?	<input type="radio"/> No <input type="radio"/> Yes	Relation:	
Has anyone in your family been diagnosed with mental illness?	<input type="radio"/> No <input type="radio"/> Yes	Relation:	
Review of Systems: Psychiatric			
Anxiety	<input type="radio"/> Yes <input type="radio"/> No	Have you been hospitalized for psychiatric problems?	<input type="radio"/> Yes <input type="radio"/> No
Depression	<input type="radio"/> Yes <input type="radio"/> No	Have you ever been admitted to a psychiatric hospital?	<input type="radio"/> Yes <input type="radio"/> No
Anorexia (starvation to control weight)	<input type="radio"/> Yes <input type="radio"/> No	Have you ever attempted suicide?	<input type="radio"/> Yes <input type="radio"/> No
Bulimia (vomiting to control weight)	<input type="radio"/> Yes <input type="radio"/> No	Have you ever been physically abused?	<input type="radio"/> Yes <input type="radio"/> No
Bipolar Disorder ("manic-depression")	<input type="radio"/> Yes <input type="radio"/> No	Have you ever been sexually abused?	<input type="radio"/> Yes <input type="radio"/> No
Alcoholism	<input type="radio"/> Yes <input type="radio"/> No	Have you ever seen a psychiatrist or counselor?	<input type="radio"/> Yes <input type="radio"/> No
Drug Dependency	<input type="radio"/> Yes <input type="radio"/> No	Are you currently seeing a psychiatrist or counselor?	<input type="radio"/> Yes <input type="radio"/> No
Schizophrenia	<input type="radio"/> Yes <input type="radio"/> No	Have you ever taken medications for psychiatric problems or for depression?	<input type="radio"/> Yes <input type="radio"/> No
Other Psychiatric Problems	<input type="radio"/> Yes <input type="radio"/> No	Have you ever been in a chemical dependency program?	<input type="radio"/> Yes <input type="radio"/> No
Psychiatrist/Therapist Name			
Psychiatrist/Therapist Address and Phone			

Review of Systems: Cardiovascular			
Heart attack	<input type="radio"/> Yes <input type="radio"/> No	Ankle/Leg Ulcers	<input type="radio"/> Yes <input type="radio"/> No
Angina (chest pain with activity)	<input type="radio"/> Yes <input type="radio"/> No	Heart Bypass/Valve Replacement	<input type="radio"/> Yes <input type="radio"/> No
Rhythm Disturbance/Palpitations	<input type="radio"/> Yes <input type="radio"/> No	Pacemaker	<input type="radio"/> Yes <input type="radio"/> No
Congestive Heart Failure	<input type="radio"/> Yes <input type="radio"/> No	Clogged Heart Arteries	<input type="radio"/> Yes <input type="radio"/> No
High Blood Pressure	<input type="radio"/> Yes <input type="radio"/> No	Rheumatic fever/Valve Damage	<input type="radio"/> Yes <input type="radio"/> No
Ankle Swelling	<input type="radio"/> Yes <input type="radio"/> No	Heart Murmur	<input type="radio"/> Yes <input type="radio"/> No
Varicose Veins	<input type="radio"/> Yes <input type="radio"/> No	Irregular Heart Beat	<input type="radio"/> Yes <input type="radio"/> No
Hemorrhoids	<input type="radio"/> Yes <input type="radio"/> No	Cramping in Legs when Walking	<input type="radio"/> Yes <input type="radio"/> No
Phlebitis	<input type="radio"/> Yes <input type="radio"/> No	Other, _____	<input type="radio"/> Yes <input type="radio"/> No
Review of Systems: Respiratory			
Asthma	<input type="radio"/> Yes <input type="radio"/> No	Pulmonary Embolism	<input type="radio"/> Yes <input type="radio"/> No
Emphysema	<input type="radio"/> Yes <input type="radio"/> No	Hypoventilation Syndrome	<input type="radio"/> Yes <input type="radio"/> No
Bronchitis	<input type="radio"/> Yes <input type="radio"/> No	Cough up Blood	<input type="radio"/> Yes <input type="radio"/> No
Pneumonia	<input type="radio"/> Yes <input type="radio"/> No	Snoring	<input type="radio"/> Yes <input type="radio"/> No
Chronic Cough	<input type="radio"/> Yes <input type="radio"/> No	Sleep Apnea	<input type="radio"/> Yes <input type="radio"/> No
Shortness of Breath	<input type="radio"/> Yes <input type="radio"/> No	Lung Cancer	<input type="radio"/> Yes <input type="radio"/> No
Use of CPAP or Oxygen Supplement	<input type="radio"/> Yes <input type="radio"/> No	Lung Surgery	<input type="radio"/> Yes <input type="radio"/> No
Tuberculosis	<input type="radio"/> Yes <input type="radio"/> No	Other, _____	<input type="radio"/> Yes <input type="radio"/> No
Review of Systems: Endocrine			
Hypothyroid (low)	<input type="radio"/> Yes <input type="radio"/> No	Diabetes (managed by diet or pills)	<input type="radio"/> Yes <input type="radio"/> No
Hyperthyroid (high/overactive)	<input type="radio"/> Yes <input type="radio"/> No	Diabetes (needing insulin shots)	<input type="radio"/> Yes <input type="radio"/> No
Goiter	<input type="radio"/> Yes <input type="radio"/> No	"Pre-diabetes" with elevated blood sugar	<input type="radio"/> Yes <input type="radio"/> No
Parathyroid	<input type="radio"/> Yes <input type="radio"/> No	Gout	<input type="radio"/> Yes <input type="radio"/> No
Elevated cholesterol	<input type="radio"/> Yes <input type="radio"/> No	Endocrine gland tumor	<input type="radio"/> Yes <input type="radio"/> No
Elevated triglycerides	<input type="radio"/> Yes <input type="radio"/> No	Cancer of endocrine gland	<input type="radio"/> Yes <input type="radio"/> No
Low blood sugar	<input type="radio"/> Yes <input type="radio"/> No	High calcium level	<input type="radio"/> Yes <input type="radio"/> No
Abnormal facial hair growth	<input type="radio"/> Yes <input type="radio"/> No	Other, _____	<input type="radio"/> Yes <input type="radio"/> No

Review of Systems: Gastrointestinal			
Heartburn	<input type="radio"/> Yes <input type="radio"/> No	Black, Tarry Stools	<input type="radio"/> Yes <input type="radio"/> No
Hiatal Hernia	<input type="radio"/> Yes <input type="radio"/> No	Rectal Bleeding	<input type="radio"/> Yes <input type="radio"/> No
Ulcers	<input type="radio"/> Yes <input type="radio"/> No	Polyyps	<input type="radio"/> Yes <input type="radio"/> No
Diarrhea	<input type="radio"/> Yes <input type="radio"/> No	Abdominal Pain	<input type="radio"/> Yes <input type="radio"/> No
Blood in Stool	<input type="radio"/> Yes <input type="radio"/> No	Enlarged Liver	<input type="radio"/> Yes <input type="radio"/> No
Change in Bowel Habit	<input type="radio"/> Yes <input type="radio"/> No	Cirrhosis/Hepatitis	<input type="radio"/> Yes <input type="radio"/> No
Constipation	<input type="radio"/> Yes <input type="radio"/> No	Gallbladder Problems	<input type="radio"/> Yes <input type="radio"/> No
Irritable Bowel	<input type="radio"/> Yes <input type="radio"/> No	Jaundice	<input type="radio"/> Yes <input type="radio"/> No
Colitis	<input type="radio"/> Yes <input type="radio"/> No	Pancreatic Disease	<input type="radio"/> Yes <input type="radio"/> No
Crohns Disease	<input type="radio"/> Yes <input type="radio"/> No	Unusual Vomiting	<input type="radio"/> Yes <input type="radio"/> No
Hemorrhoids	<input type="radio"/> Yes <input type="radio"/> No	Surgery	<input type="radio"/> Yes <input type="radio"/> No
Fissures	<input type="radio"/> Yes <input type="radio"/> No	Cancer	<input type="radio"/> Yes <input type="radio"/> No
Review of Systems: Bladder/Kidney			
Kidney Stones	<input type="radio"/> Yes <input type="radio"/> No	Burning on Urination	<input type="radio"/> Yes <input type="radio"/> No
Blood in Urine	<input type="radio"/> Yes <input type="radio"/> No	Loss of Bladder Control (Leaking Urine)	<input type="radio"/> Yes <input type="radio"/> No
Prostate Problems	<input type="radio"/> Yes <input type="radio"/> No	Trouble Starting Urination	<input type="radio"/> Yes <input type="radio"/> No
Kidney Failure	<input type="radio"/> Yes <input type="radio"/> No	Cancer	<input type="radio"/> Yes <input type="radio"/> No
Date of your last PSA test (men):	Date _____	Surgery	<input type="radio"/> Yes <input type="radio"/> No
Review of Systems: Gynecologic/Obstetrics			
Are you pregnant?	<input type="radio"/> Yes <input type="radio"/> No	Date of Last Menstrual Period:	
Do you plan to have more children?	<input type="radio"/> Yes <input type="radio"/> No	How many children do you have?	No. _____
Problems Conceiving (Infertility)	<input type="radio"/> Yes <input type="radio"/> No	How many pregnancies have you had?	No. _____
Menstrual Irregularity	<input type="radio"/> Yes <input type="radio"/> No	How many miscarriages or abortions have you had?	No. _____
Menstrual Pain	<input type="radio"/> Yes <input type="radio"/> No	Date of Last Pap Smear (women):	Date _____
Excessively Heavy Periods	<input type="radio"/> Yes <input type="radio"/> No	When did you start your menses?	Age: _____
Are you post menopausal?	<input type="radio"/> Yes <input type="radio"/> No	Date of Menopause Onset:	
Uterine/Ovarian Cancer	<input type="radio"/> Yes <input type="radio"/> No	Surgery	<input type="radio"/> Yes <input type="radio"/> No



Review of Systems: Musculoskeletal			
Arthritis	<input type="radio"/> Yes <input type="radio"/> No	Lupus	<input type="radio"/> Yes <input type="radio"/> No
Neck Pain	<input type="radio"/> Yes <input type="radio"/> No	Scleroderma	<input type="radio"/> Yes <input type="radio"/> No
Shoulder Pain	<input type="radio"/> Yes <input type="radio"/> No	Sciatica	<input type="radio"/> Yes <input type="radio"/> No
Wrist Pain	<input type="radio"/> Yes <input type="radio"/> No	Autoimmune Disease	<input type="radio"/> Yes <input type="radio"/> No
Back Pain	<input type="radio"/> Yes <input type="radio"/> No	Muscle Pain/Spasms	<input type="radio"/> Yes <input type="radio"/> No
Hip Pain	<input type="radio"/> Yes <input type="radio"/> No	Fibromyalgia	<input type="radio"/> Yes <input type="radio"/> No
Knee Pain	<input type="radio"/> Yes <input type="radio"/> No	Broken Bones	<input type="radio"/> Yes <input type="radio"/> No
Ankle Pain	<input type="radio"/> Yes <input type="radio"/> No	Joint Replacement	<input type="radio"/> Yes <input type="radio"/> No
Foot Pain	<input type="radio"/> Yes <input type="radio"/> No	Nerve Injury	<input type="radio"/> Yes <input type="radio"/> No
Heel Pain	<input type="radio"/> Yes <input type="radio"/> No	Muscular Dystrophy	<input type="radio"/> Yes <input type="radio"/> No
Ball of Foot/Toe Pain	<input type="radio"/> Yes <input type="radio"/> No	Surgery	<input type="radio"/> Yes <input type="radio"/> No
Plantar Fasciitis	<input type="radio"/> Yes <input type="radio"/> No	Cancer	<input type="radio"/> Yes <input type="radio"/> No
Carpal Tunnel Syndrome	<input type="radio"/> Yes <input type="radio"/> No		
Review of Systems: Neurologic			
Migraine Headaches	<input type="radio"/> Yes <input type="radio"/> No	Pseudotumor Cerebri (loss of vision from high pressure in the brain)	<input type="radio"/> Yes <input type="radio"/> No
Balance Disturbance	<input type="radio"/> Yes <input type="radio"/> No	Multiple Sclerosis	<input type="radio"/> Yes <input type="radio"/> No
Seizures or Convulsions	<input type="radio"/> Yes <input type="radio"/> No	Frequency Severe Headaches	<input type="radio"/> Yes <input type="radio"/> No
Weakness	<input type="radio"/> Yes <input type="radio"/> No	Knocked Unconscious	<input type="radio"/> Yes <input type="radio"/> No
Stroke	<input type="radio"/> Yes <input type="radio"/> No	Surgery	<input type="radio"/> Yes <input type="radio"/> No
Alzheimer's	<input type="radio"/> Yes <input type="radio"/> No	Cancer	<input type="radio"/> Yes <input type="radio"/> No
Review of Systems: Blood			
Anemia (iron deficient)	<input type="radio"/> Yes <input type="radio"/> No	Superficial Blood Clot in Leg	<input type="radio"/> Yes <input type="radio"/> No
Anemia (vitamin B12 deficient)	<input type="radio"/> Yes <input type="radio"/> No	Deep Blood Clot in Leg	<input type="radio"/> Yes <input type="radio"/> No
HIV	<input type="radio"/> Yes <input type="radio"/> No	Blood Clot in Lungs (pulmonary embolism)	<input type="radio"/> Yes <input type="radio"/> No
Low Platelets (thrombocytopenia)	<input type="radio"/> Yes <input type="radio"/> No	Bleeding Disorder	<input type="radio"/> Yes <input type="radio"/> No
Lymphoma	<input type="radio"/> Yes <input type="radio"/> No	Blood Transfusion	<input type="radio"/> Yes <input type="radio"/> No
Swollen Lymph Nodes	<input type="radio"/> Yes <input type="radio"/> No	Blood Thinning Medicine Use	<input type="radio"/> Yes <input type="radio"/> No

Review of Systems: Head and Neck			
Wear Contacts/Glasses	<input type="radio"/> Yes <input type="radio"/> No	Dentures/Partial	<input type="radio"/> Yes <input type="radio"/> No
Vision Problems	<input type="radio"/> Yes <input type="radio"/> No	Oral Sores	<input type="radio"/> Yes <input type="radio"/> No
Hearing Problems	<input type="radio"/> Yes <input type="radio"/> No	Hoarseness of Voice	<input type="radio"/> Yes <input type="radio"/> No
Sinus Drainage	<input type="radio"/> Yes <input type="radio"/> No	Head/Neck Surgery	<input type="radio"/> Yes <input type="radio"/> No
Neck Lumps	<input type="radio"/> Yes <input type="radio"/> No	Cancer	<input type="radio"/> Yes <input type="radio"/> No
Difficulty Swallowing	<input type="radio"/> Yes <input type="radio"/> No		
Review of Systems: Breast			
Lumps	<input type="radio"/> Yes <input type="radio"/> No	Nipple Discharge	<input type="radio"/> Yes <input type="radio"/> No
Pain	<input type="radio"/> Yes <input type="radio"/> No	Surgery	<input type="radio"/> Yes <input type="radio"/> No
Fibrocystic Disease	<input type="radio"/> Yes <input type="radio"/> No	Cancer	<input type="radio"/> Yes <input type="radio"/> No
Review of Systems: Skin			
Rashes under Skin Folds	<input type="radio"/> Yes <input type="radio"/> No	Frequent Skin Infections	<input type="radio"/> Yes <input type="radio"/> No
Keloids (excessively raised scars)	<input type="radio"/> Yes <input type="radio"/> No	Surgery	<input type="radio"/> Yes <input type="radio"/> No
Poor Wound Healing	<input type="radio"/> Yes <input type="radio"/> No	Cancer	<input type="radio"/> Yes <input type="radio"/> No
Review of Systems: Constitutional			
Fevers	<input type="radio"/> Yes <input type="radio"/> No	Weight Loss	<input type="radio"/> Yes <input type="radio"/> No
Night Sweats	<input type="radio"/> Yes <input type="radio"/> No	Chronic Fatigue	<input type="radio"/> Yes <input type="radio"/> No
Anemia	<input type="radio"/> Yes <input type="radio"/> No	Hair Loss	<input type="radio"/> Yes <input type="radio"/> No