M. Kathryn Schaefer, M.D.

850 W. Hind Drive Suite #102, Aina Hina Professional Building

Phone: (808) 261-1121 or (808) 358-2493, Fax: 808-762-8392

Patient Name:_____ Date of Visit: _____

Please tell me if you are having any of these problems lately - or - No Change from last visit [ ]

PLEASE CHECK ALL THAT APPLY		PLEASE CHECK ALL THAT APPLY	
Constitutional:	**YES**	**Genitourinary:**	**YES**
Headache		Pain with passing water	
Fatigue		Pain when having sex	
Chills or Night sweats		Pain or lumps in the testicles	
Weight gain or loss		Hard time passing water	
Eyes:		Hard time holding water	
Eye Pain		Blood or pus in the urine	
Redness or Dryness		Going to the bathroom too often	
Blurred or double vision		**Neurological:**	
Partial blindness		Dizziness or balance problems	
Ears:		Weakness or numbness	
Ear pain or bleeding		Tingling or pins and needles	
Hard or hearing		Trouble talking	
Ringing in ears		Trouble Swallowing	
Nose:		Feeling irritable or violent	
Pain or bleeding in the nose		Angry most of the time	
Change of taste or smell		Forgetting too much	
Runny nose or sinus trouble		**Psychiatric:**	
Mouth:		Depression or anxiety	
Pain or sores in mouth		Unusual fears or violent thoughts	
Bleeding in mouth		Don't feel like eating	
Throat:		Don't feel like having sex	
Pain or sores in the throat		**Sleep:**	
Swollen nodes or lumps		Hard time getting to sleep	
Gastrointestinal:		Hard time staying asleep	
Heartburn		Don't wake up rested	
Belly pain or cramping		Wake up scared or panting	
Nausea or throwing up		**Skin:**	
Bloating or constipation		Rash from the sun or medications	
Bowel accidents		Boils or other rashes	
Cardiovascular:		Cuts, scrapes, or bruises	
Pain or pressure in the chest		**Activities of Daily Living:**	
Fluttery heart (palpitations)		Need help getting out of bed	
Swollen feet or ankles		Need help using the toilet	

Respiratory:		Need help getting dressed	
Short of breath		Need help brushing teeth	
Wheezing or coughing		Need help bathing	
Endocrine:		Need help combing your hair	
Thirsty all the time		Need help counting money	
Urinating too often		Need help taking medications	
Feeling too hot or too cold		Cannot drive anymore	

Any other problems or additional details?

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Your Signature: _____