

Patients Name _____ Date _____

Are you claustrophobic? Yes No History of kidney disease? Yes No

Are you pregnant or think you may be? Yes No

Have you developed a new medical problem since your last visit? _____

Main reason for today's visit: _____

Please put a check by the symptoms you are currently experiencing:

Fatigue Abdominal Pain None

Fever Constipation

Weight Gain >10 lbs. Diarrhea

Weight Loss > 10 lbs. Nausea

Bruising Backache

Hair Loss Joint Pain

Itching Muscle Cramps

Rash Decreased Memory

Blurred Vision Dizziness

Double Vision Fainting

Visual Loss Headaches

Decreased Hearing Seizures

Tinnitus Vertigo

Sinus Pain Weakness in Extremities

Hoarseness Anxiety

Cough Change in Sleep Pattern

Difficulty Breathing Depression

Sputum Production Inability to Concentrate

Chest Pain Abnormal Bleeding

Irregular Heart Beat Anemia

Leg Pain and/or Swelling Easy Bruising