NAME _________________________________ DOB__________________

APPT WITH DR__________________________ VISIT DATE______________

REVIEW OF SYMPTOMS

DO YOU HAVE ANY RECENT OR ONGOING SYMPTOMS LISTED BELOW:

Constitutional Symptoms: Yes/No/NA (not applicable)

Are you in good health..___/__/___
Fatigue..___/__/___
Recent fever ....___/__/___
Chills ....___/__/___
Night sweats...___/__/___
Recent weight change ....___/__/___
Other ....___/__/___

Eyes:

Wear contacts or glasses ....___/__/___
Eye pain ....___/__/___
Redness ....___/__/___
Discharge ....___/__/___
Loss or blurring of vision..___/__/___
Double vision ....___/__/___
Other ....___/__/___

Ears, nose, mouth, throat:

Hearing loss ....___/__/___
Ringing in ears ....___/__/___
Ear pain ....___/__/___
Ear drainage ....___/__/___
Nasal obstruction/discharge ....___/__/___
Sinusitis..___/__/___
Snoring...___/__/___
Nosebleeds ....___/__/___
Tooth or gum problems...___/__/___
Sore tongue or mouth sores...___/__/___
Sore throat...___/__/___
Hoarseness ....___/__/___
Difficult swallowing ....___/__/___
Other ....___/__/___

Cardiovascular: Yes/No/NA

Chest pain or pressure ....___/__/___
Heart racing, skipping or irregular.......................................___/__/___
Angina...___/__/___
Blood pressures running high ....___/__/___
Blackouts, faints or loss of consciousness ....___/__/___
Shortness of breath at night..___/__/___
Difficulty walking two blocks due to leg pain......................___/__/___
Swelling in ankles or feet...___/__/___
Other ....___/__/___

Respiratory:

Difficulty breathing...___/__/___
Wheezing ....___/__/___
Coughing at night..___/__/___
Cough (persistent) ....___/__/___
Sputum production..___/__/___
Coughing or spitting up blood ....___/__/___
Other ....___/__/___

Gastrointestinal:

Cramping or abdominal pain ....___/__/___
Nausea..___/__/___
Heartburn or indigestion ....___/__/___
Vomiting ....___/__/___
Vomiting of blood..___/__/___
Frequent diarrhea ....___/__/___
Painful bowel movements..___/__/___
Constipation ....___/__/___
Blood in stool or black stools...___/__/___
Hemorrhoids or piles...___/__/___
Other ....___/__/___

Male Genitourinary:

Burning or painful urination ....___/__/___
Frequent urination...___/__/___
Leakage of urination ....___/__/___
Blood in urine ....___/__/___
Change in urine stream ....___/__/___
Difficulty in emptying bladder...___/__/___
Night time urination ....___/__/___
Bedwetting ....___/__/___
Discharge from penis ....___/__/___
Testicular pain or swelling...___/__/___

Problems with sexual function ....___/__/___
Other ....___/__/___

Female Genitourinary: Yes/No/NA

When was the first day of your last menstrual period ....___/__/___
Burning or painful urination ....___/__/___
Frequent urination ....___/__/___
Leakage of urine ....___/__/___
Urinary urgency ....___/__/___
Blood in urine ....___/__/___
Night time urination ....___/__/___
Vaginal itching ....___/__/___
Vaginal discharge ....___/__/___
Abnormal periods ....___/__/___
Painful periods ....___/__/___
Spotting between periods ....___/__/___
Hot flashes or flushes ....___/__/___
Vaginal bleeding since menopause ....___/__/___
Painful sexual activity ....___/__/___
Pelvic pain ....___/__/___
Breast lumps or nipple discharge ....___/__/___
Other ....___/__/___

Musculoskeletal:

Neck pain ....___/__/___
Back pain ....___/__/___
Muscle pain ....___/__/___
Joint pain and swelling ....___/__/___
Other ....___/__/___

Skin:

Skin rashes ....___/__/___
Lumps, bumps or moles you are concerned with ....___/__/___
Changes in hair ....___/__/___

Neurological:

Headache ....___/__/___
Localized or persistent weakness ....___/__/___
Generalized weakness ....___/__/___
Persistent tingling or numbness ....___/__/___
Seizures ....___/__/___
Tremors ....___/__/___
Dizziness ....___/__/___

Psychiatric: Yes/No/NA

Anxiety or excessive worry ....___/__/___
Appetite disturbance ....___/__/___
Sleep disturbance ....___/__/___
Difficulty concentrating ....___/__/___
Memory problems ....___/__/___
Moodiness or irritability ....___/__/___
Low self esteem ....___/__/___
Hopelessness ....___/__/___
Depression...___/__/___
Suicidal thoughts or attempts..___/__/___
Obsessive thoughts or compulsions ....___/__/___
Disturbing thoughts or feelings..___/__/___
Attention deficit disorder ....___/__/___
Other ....___/__/___

Endocrine:

Increased thirst ....___/__/___
Heat or cold intolerance ....___/__/___
Increased appetite and eating ....___/__/___
Excessive sweating ....___/__/___
Other ....___/__/___

Hematologic/Lymphatic:

Abnormal bruising or bleeding ....___/__/___
Other ....___/__/___

Allergic/Immunologic:

Itchy eyes ....___/__/___
Itchy nose ....___/__/___
Frequent sneezing ....___/__/___
Hives ....___/__/___
Other ....___/__/___